2017-2018

$1,000,000

Student Accident Insurance

Pays regardless of other insurance

QBE

Who is eligible

The policy is available to all enrolled students, faculty and administration of a participating school.

Who pays the premium

Coverage is purchased by the parent or guardian of enrolled students or by individual faculty or administrative members interested in enrolling in the program.

Coverage term

Coverage is effective when the premium is received by the school administrator or the effective date of the policy, whichever is later. Coverage expires at 12:01 a.m. of the first day of the next school year or the anniversary of the policy, whichever is earlier. Individual coverage ends when affiliation is ended with the participating school.

Choice of two school approved insurance plans with optional Extended Dental Benefit

School time accident coverage

Insurance coverage for the hours and days when school is in session and while attending school-sponsored and supervised activities on or off the school premises.

Includes:

- Activities during school year
- Travel to and from school
- School-supervised and sponsored activities
- Class trips
- Religious services

Full-time 24-hour accident coverage

Insurance coverage is in force around the clock.

Includes:

- Any covered activity, regardless of location
- 24-hour-a-day coverage, including summer
- Weekends and vacation periods
- Protection at home or while away

PLAN ADMINISTRATOR

The Allen J. Flood Companies
Two Madison Ave.
Larchmont, NY 10538
800.734.9326

LOCAL AGENT

Darien Insurance Center Inc.
55 Frontier Road
Cos Cob, CT 06807
203.344.9545

Coverage becomes effective on the earliest of the following: (1) the first day of school, if signed enrollment form and premium are received before the seventh school day; or (2) the date enrollment form and premium are received by the school administrator.

Accident Insurance Protection

Providing a maximum of $1,000,000 Accident Medical Expense

Primary Coverage – pays regardless of other health insurance

Provides for payment of Usual and Customary (U&C) expenses incurred for treatment of an injury caused by a covered accident, subject to the maximums stated in the policy. Covered expenses must be for appropriate treatment and the first expense must be incurred within 90 days following the covered accident. To be payable, expenses must be incurred within 365 days after the covered accident. All benefits will be based on the normal charge, in the absence of insurance, made by the provider for any appropriate treatment, but not more than the prevailing charge in the area for like services by a provider with similar training and experience. Where appropriate, usual and customary charges will be based on a relative value schedule appropriate to the area and the type of service provided.

Covered expenses per covered accident

Plan A

Hospital services

Daily room & board: average semi-private rate, up to	$250/day
Intensive care for 7 days	U&C up to $350/day
Miscellaneous hospital services, while confined or when surgery performed	U&C up to $2,500
Emergency room (outpatient)	U&C up to $200

Physician's services

Surgery (incl. pre- and post-operative care) Computed from the 1974 California Relative Value Schedule- Number of units times unit value of	$150
Visits (when no surgery paid), except physiotherapy and similar treatments, per visit up to	$40 - first visit $20 - After
Anesthetic and asst. surgeon, percent of surgery benefit	30%
Consultants, second opinions	U&C up to $100

Lab & X-ray, except dental X-rays

X-ray maximum	$300
Laboratory maximum	$150

Additional services

Physiotherapy or similar treatment - In hospital	Inc. in hosp. misc
- Out of hospital (maximum 5 visits)	$30/visit
Prescribed orthopedic appliances Maximum - In hospital	Inc. in hosp. misc
- Out of hospital	up to $250
Registered or licensed nurse, when prescribed	U&C
Ambulance to initial treatment facility	U&C
Prescribed drugs and medicines	up to $100
Accidental ingestion of controlled drugs:	
- Inpatient confinement	U&C up to 30 Days
- Outpatient treatment	U&C up to $500
Home health care services	as required by CT Statute 38a-493

Eyeglasses, contact lenses, hearing aids

Replacement, when broken as the result of a covered injury requiring medical treatment	U&C up to $125

Dental services (includes dental X-rays)*

Treatment, repair or replacement - each tooth	U&C up to $250

Plan B

Hospital services

Daily room & board: Average semi-private rate, up to	$75/day
Intensive care for 7 days	U&C up to $125/day
Miscellaneous hospital services, while confined or when surgery performed	U&C up to $1,000
Emergency room (outpatient)	U&C up to $100

Physician's services

Surgery (incl. pre- and post-operative care) Computed from the 1974 California Relative Value Schedule- Number of units times unit value of	$100
Visits (when no surgery paid), except physiotherapy and similar treatments, per visit up to	$25 - first visit $10 - After
Anesthetic and asst. surgeon, percent of surgery benefit	20%
Consultants, second opinions	U&C up to $50

Lab & X-ray, except dental X-rays

X-ray maximum	$150
Laboratory maximum	$75

Additional services

Physiotherapy or similar treatment - In hospital	Inc. in hosp. misc
- Out of hospital (maximum 5 visits)	$20/visit
Prescribed orthopedic appliances Maximum - In hospital	Inc. in hosp. misc
- Out of hospital	up to $50
Registered or licensed nurse, when prescribed	U&C
Ambulance to initial treatment facility	U&C
Prescribed drugs and medicines	up to $25
Accidental ingestion of controlled drugs	
- Inpatient confinement	U&C up to 30 Days
- Outpatient treatment	U&C up to $500
Home health care services	as required by CT Statute 38a-493

Eyeglasses, contact lenses, hearing aids

Replacement, when broken as the result of a covered injury requiring medical treatment	U&C up to $25

Dental services (includes dental X-rays)*

Treatment, repair or replacement - each tooth	U&C up to $100

*If there is more than one way to treat a dental problem, benefits will be paid for the least expensive procedure, provided it meets acceptable dental standards.

Accidental death, dismemberment, or loss of sight

Provides for payments of benefits in accordance with the following table when loss results from a covered accident. Loss must result within 365 days of the accident. If more than one loss results from any one accident, only the largest amount will be paid.

Loss of life	$10,000
Both hands or both feet, or the sight of both eyes	$20,000
One hand and one foot	$20,000
One hand and the sight of one eye	$20,000
One foot and the sight of one eye	$20,000
One hand or one foot, or the sight of one eye	$10,000

"Loss" means with regard to hands and feet, complete severance through or above the wrist or ankle joint; with reference to the eye, total, permanent loss of all vision that is irrecoverable by natural, surgical or artificial means. "Severance" means the complete separation and dismemberment of the part from the body.

	Annual Premium	
Coverage chosen:	**Plan A**	**Plan B**
School Time Coverage	❑ $16	❑ $8
School Time with Extended Dental	❑ $24	❑ $16
24-Hour Coverage	❑ $54	❑ $30
24-Hour Coverage with Extended Dental	❑ $62	❑ $38

$50,000 maximum Extended Dental benefit

Coverage is in effect 24 hours a day

By adding an additional premium, dental benefits may be extended to provide payment of covered expenses to a maximum of $50,000. This additional benefit provides payment for the U&C expenses incurred within two years from the date of the covered accident for treatment, repair and replacement of each injured natural tooth, including examination, diagnosis, X-ray, restorative treatment, endodontics and oral surgery, plus for the replacement of caps, crowns, dentures and orthodontic appliances.

Limitations: When this benefit is selected, dental services will only be covered under this benefit and not under the Accident Medical Plan. When certified by a dentist that treatment must be deferred until after the two-year benefit period, benefits will be paid to a maximum of $600 per covered accident. If there is more than one way to treat a dental problem, covered benefits will be paid for the least expensive procedure provided it meets acceptable dental standards.

All claims for deferred dental benefits must be submitted no later than 30 days after the end of the two-year benefit period.

Claims procedure: In case of accident, notify school immediately. Secure claim form from your school, attach bill(s) to completed claim form and mail to the address indicated on the claim form. **Claims for benefits must be filed within 90 days from date of loss, or as soon as reasonably possible.**

Important notice: This information is a brief description of the important features of this insurance plan. It is not a contract. Terms and conditions of coverage are set forth on policy form series BAM-03-100000, BAM-09-100000, or applicable state versions. The Blanket Accident Medical Insurance Policy is subject to the laws of the jurisdiction in which it is issued. It is not available in all states. Additional exclusions and limitations apply. The availability of this offer may change. You may review a copy of the policy upon request. **Please keep this material as a reference. An individual ID card will not be issued.**

Primary Accident Medical Coverage -

Pays regardless of any other Health Care Plan you may have

Not sure which plan is right for you?

Call your local agent

Darien Insurance Center Inc.

203.344.9545

"Health Care Plan" means any arrangement, whether individually purchased or incident to employment or membership in an association or other group, which provides benefits or services for health care, dental care, disability benefits or repatriation of remains. A Health Care Plan includes group, blanket, franchise, family or individual insurance policies, subscriber contracts, uninsured agreements or arrangements, coverage provided through Health Maintenance Organizations, Preferred Provider Organizations and other prepayment, group practice and individual practice plans, medical benefits provided under automobile "fault" and "no-fault" - type contracts, medical benefits provided by any governmental plan or coverage or other benefit law, except a state-sponsored Medicaid plan; or a plan or law providing benefits only in excess of any private or non-governmental plan, and other valid and collectible medical or health care benefits or services.

Exclusions and limitations

Benefits will not be paid for injuries caused by:

(1) suicide, intentionally self-inflicted injury, or any attempt thereat while sane or insane;
(2) commission or attempt to commit a felony or an assault, or commission of or active participation in a riot or insurrection;
(3) declared or undeclared war or act of war;
(4) services or treatment provided by persons who do not normally charge for services, unless there is a legal obligation to pay;
(5) flight in, boarding or alighting from an aircraft except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
(6) travel in or on any on-road or off-road vehicle that does not require motor vehicle licensing;
(7) bungee-cord jumping, parachuting, skydiving, parasailing, hang-gliding;
(8) an accident if the covered person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless the covered person holds a valid learners permit and the covered person is receiving instruction from a driver's education instructor;
(9) services or treatment rendered by any person who is employed or retained by the policyholder or living in the covered person's household, a parent, sibling, spouse or child either of the covered person or the covered person's spouse; the covered person;
(10) cosmetic surgery, except for reconstructive surgery needed as the result of a covered injury;
(11) injuries compensable under workers' compensation law or any similar law;
(12) sickness, disease, bodily or mental illness, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound, or accidental ingestion of contaminated food;
(13) the covered person being legally intoxicated as determined according to the laws of the jurisdiction in which the covered accident occurred or voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a physician and taken in accordance with the prescribed dosage;
(14) any hospital stay or days of a hospital stay that are not appropriate treatment for the condition and locality;
(15) participation or practice for non-school sponsored skiing, ice hockey, lacrosse, soccer or tackle football (applicable to school time coverage only);
(16) taking part in senior high school interscholastic football and sports, including travel to and from games and practice, unless specifically provided for in the Policy.

After selecting the school-approved insurance plan that's best for you:

- ❑ Detach and complete the enrollment form
- ❑ Enclose a check or money order
- ❑ Do not send cash
- ❑ Return enrollment form and check or money order to:

The Allen J. Flood Companies
Two Madison Ave.
Larchmont, NY 10538

(Detach Here)

Student Accident Insurance

2017/2018 Enrollment Form

School name: _____

Person to be insured: _____

Address: _____

City _____ State: _____ ZIP _____

Phone: _____

Date of Birth: _____

Social Security #: _____

Parent Signature: _____

Policy Number (company use only): _____

District name: _____ Grade/dept: _____

Student accident insurance chosen for: ❑ Student ❑ Faculty ❑ Administration

Coverage chosen:	Annual Premium Plan A	Plan B
School Time Coverage	❑ $16	❑ $8
School Time with Extended Dental	❑ $24	❑ $16
24-Hour Coverage	❑ $54	❑ $30
24-Hour Coverage with Extended Dental	❑ $62	❑ $36

Date: _____ Amount enclosed: _____ (Do not send cash)

Please include check or money order payable to: **QBE Insurance Corporation**

There is no obligation to purchase this insurance plan.

Do you want this insurance? ❑ Yes ❑ No

Student Accident Insurance
Instructions for Filing a Claim

The accident insurance plan is designed to cover all enrolled students of the school while they participate in school sponsored and supervised activities. The plan will consider reimbursement for eligible expenses which are not payable by your healthcare plan or any other insurance plan providing reimbursement for medical expenses. Therefore, prior to filing a claim against the accident insurance policy, you must first file the claim with your own healthcare plan. Please observe the following claim filing procedures:

(Please include the policy number on all correspondence to facilitate the handling of your claim)

1. Obtain a claim form from the School. Only one form is needed for each accident, regardless of the number of expenses incurred for the particular accident.

2. Part I of the claim form should be completed and signed by a School official. Part I requests a description of how the accident occurred. Please check to see that a complete description is provided. For example, "Basketball" is not acceptable; however, "Twisted left ankle while playing basketball" is acceptable.

3. Part II of the claim form should be completed and signed by the claimant's parent or guardian. All questions in Part II must be completed in order for the company to examine your claim. Please do not leave any questions blank. Part II includes the section entitled "Authorization to Release Information."

4. An Itemized Bill should be submitted for each expense incurred. Itemized Bills provide the dates of service, the procedure codes, the diagnosis and the charge(s). "Balance Due" bills and/or collection notices are not acceptable because they do not provide all of the information needed to properly examine a claim.

5. When submitting charges for Physical Therapy, the itemized bill must be accompanied by the prescription and include the frequency and the duration of the treatment.

6. Submit copies of the Explanation of Benefits (EOB) statements from your own healthcare plan. The EOB's will show how much your healthcare plan paid for the services rendered and the amount which is your responsibility. There should be an EOB for each Itemized Bill you have submitted for reimbursement.

7. Mail or email the fully completed claim form, each Itemized Bill (and the prescription, if applicable) and the corresponding EOB to the following address: **(Please include the Policy Number on all correspondence)**

NAHGA Claim Services
PO Box 189
Bridgton, ME 04009
claims@nahga.com
Fax 207-647-4569

Please remember, the policy is an Accident insurance policy. It does not provide reimbursement for illness or for injuries that are not the result of an Accident. It is subject to exclusions and limitations. The policy may also contain a deductible which may be the claimant's responsibility.

QBE Insurance Corporation

Accident Claim Form

Mail to

NAHGA Claim Services
PO Box 189
Bridgton, ME 04009
E-mail: claims@nahga.com
Fax: (207) 647-4569
Questions? Contact (800) 952-4320

MAGNACARE First Health

In NY, network access provided by MagnaCare. Outside the MagnaCare network, access will be provided by First Health.

Caution

Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. **Residents of the following states, please see last page: CA, CO, DC, FL, NY, TN, TX and VA.**

Instructions

- **Part I** - Must be completed by Policyholder.
- **Part II** - Must be completed by Claimant or by the Parent or Guardian, if the Claimant is a minor.
- All fields must be completed.
- Send copies of itemized bills showing provider's name, address, Tax ID number, diagnosis and procedure codes.
- Attach Explanation of Benefits, additional bills with record of payment or denial from primary insurance carrier. This does not apply if the accident policy provides primary coverage.
- All benefits will be payable to the physicians and providers, unless accompanied by paid receipts.
- If employed, but have no other insurance, forward employer(s) letter on employer(s) letterhead to that effect.
- For additional instructions about how to file a claim please visit www.ajfusa.com/claims

Claimants eligible for Medicaid benefits must first file for benefits under this policy before submitting expenses to Medicaid.

Part I – Policyholder Report

Name of Policyholder | Policy number

Policyholder address | City | State | Zip code

Policyholder contact | Email | Fax | Phone

Last name of Claimant | First name of Claimant | Social Security number

Date of birth | Sex ☐ Male ☐ Female | Grade (if applicable) | Check one (if applicable) ☐ Day School ☐ Boarding School

Nature of injury (Describe, fully indicate what part of body was injured – e.g. broken arm, sprained ankle)
Must be a bodily injury due to accident

Describe how the accident occurred, provide all details. Attach a separate sheet, if necessary **(include name of Sport/Activity).**

Did accident occur:

During a Policyholder supervised/authorized activity?	☐ Yes	☐ No
During a Policyholder sponsored activity?	☐ Yes	☐ No
During scheduled Policyholder hours?	☐ Yes	☐ No
While traveling to or from a Policyholder sponsored and supervised activity?	☐ Yes	☐ No
Off Policyholder premises, at home, during the weekend, holiday or summer vacation?	☐ Yes	☐ No

Date of accident | Time of accident ☐ AM ☐ PM | Place of accident | First treatment date

Name and title of person supervising activity? | Was he or she a witness? ☐ Yes ☐ No

List other Policyholder insurance. Attach separate sheet, if necessary. | Policy number(s)

Signature of authorized Policyholder representative | **Title** | **Date**

X

Part II – To be completed by Claimant or Parent / Guardian, if Claimant is a minor

Name of Claimant or Father/Guardian | Social Security number | E-mail address

Name of Mother or Guardian | Social Security number | E-mail address

Street address of Parents or Claimant Guardian | City | State | Zip code

Telephone number | Father or Guardian's insurance company | Mother or Guardian's insurance company

Name and address of Claimant or Father/Guardian's employer, if a minor. | City | State | Zip code

Name and address of Claimant or Mother/Guardian's employer, if a minor. | City | State | Zip code

List all other insurance policies under which Claimant is insured | Policy number

Is the Claimant enrolled in, a member of, or a participant of any of the following as an individual, employee or dependent? If so, please provide a copy of insurance card (front and back).

Preferred Provider Organization (PPO) or similar prepaid health plan? ☐ Yes ☐ No

If Yes, name of PPO or organization

Health Maintenance Organization (HMO) or similar prepaid health plan? ☐ Yes ☐ No

If Yes, name of HMO or organization

If Claimant has health care coverage as a dependent from a previous marriage as mandated in a divorce decree, please provide the following:

Name of Policyholder | Name of insurance company | Policy number

Affidavit

I verify that the statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the Company to the extent for which the Company would not have been liable.

Authorization to Release Information

I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to any QBE company, its employees, and authorized agents for the purpose of validation and determining benefits payable. I further authorize any QBE company to furnish the Policyholder or its agents, any and all information with respect to my insurance claim for the purpose of assisting with claims adjudication. This data may be extracted for audit or statistical purposes. I understand that I have the right to revoke this authorization in writing at any time and that such a revocation is not effective to the extent that such authorization has already been relied upon.

Payment Authorization

I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices, unless paid receipts accompany this form.

Signature (Parent or guardian, if the claimant is a minor) **Date**

X

California and Texas residents	Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Colorado residents	It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
District of Columbia residents	WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida residents	Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.
New York residents	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.
Tennessee residents	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
Virginia residents	Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.