STUDENT ACCIDENT INSURANCE
2013-2014 SCHOOL YEAR

This is a reminder to parents with a child or children **attending** school in our School District that we do not carry medical insurance on students, but do provide parents with the opportunity to select a primary excess group insurance plan for students. Student accident insurance can help you eliminate the possibility of out-of-pocket expenses, since many group insurance policies no longer pay full hospital and medical expenses and may require a deductible or co-insurance. There are two plans available for your consideration:

- **Plan #1 School Time Coverage** – Costs $30 per student – This will cover injury occurring while the student is traveling to and from school, while attending school sponsored activities such as plays, assemblies, class trips, interscholastic sports other than Sr. high football, intramural sports, gym and physical education classes, etc.

- **Plan #2 24 Hour Coverage** – Costs $116 per student – This will cover all of the above, plus accidents occurring away from school, in the evenings and on weekends, vacations, etc.

Please note that the plans should be considered in conjunction with any other family medical insurance you may have.

Please see the attached Brochure for a complete description of the plans and the various coverage options. If you have any questions, please call an Insurance Broker at American Management Advisors directly at (215) 946-8888 between 8:00a.m. and 4:30 p.m.

PLEASE DO NOT SEND CASH!! Completed applications (found on page five of the attached brochure) should be returned by mail with a check or money order for the correct premium, directly to:

American Management Advisors, Inc.
P.O. Box 366
Langhorne, PA 19047-0366

DO NOT RETURN THE APPLICATION & PAYMENT TO YOUR STUDENT'S SCHOOL

This insurance can be purchased anytime during the 2013-2014 school year.

Parents enrolling more than one child must fill out an application for each child, write a separate check or obtain a money order for each child/student being enrolled and mail in separate envelopes to the address above. Your cancelled check or money order receipt is your proof of payment. Thank you!

Up to **$1,000,000** Student Accident Medical Insurance Protection

Administered By:

AMERICAN MANAGEMENT ADVISORS, INC.

P.O. Box 366, Langhorne, PA 19047-0366

(215) 946-8888

2013-2014

Underwritten By:

ACE American Insurance Company

Philadelphia, PA 19106

AH-10327-PA (Form PA AA-X/NS) **Ver. 1**

BEST BUY

24-HOUR COVERAGE

Around-the-clock accident coverage for your child at any time. Insurance Protection during vacations, weekends and school days.

24-Hour Coverage is your best buy because it is not limited to school connected accidents but also covers accidental Injury at home or away. ANY COVERED ACTIVITY - ANYTIME - ANYWHERE. Continuous Insurance protection from the effective date to the opening of the next school term.

Coverage becomes effective on the date the Application and Premium are received by the school. Once effective, coverage continues until the first day of school in the following year or until the policy with the school expires, whichever occurs first.

SCHOOL TIME ACCIDENT COVERAGE

Insurance coverage for the hours and days when school is in session and while attending school sponsored and supervised activities.

- During school year • School supervised activities
- On the school premises • Class trips
- Travel to and from school

This coverage is subject to the terms and conditions stated in the policy.

ACCIDENTAL DEATH AND DISMEMBERMENT OR LOSS OF SIGHT

When Injury results in an Insured's death, the Company will pay a $5,000 accidental death benefit. When Injury results in any one of the following covered losses within 365 days from the date of a covered accident, the Company will pay the benefit shown in the schedule below. Only one benefit, the largest, will be paid for more than one loss (including death) resulting from the same covered accident.

For Loss of:

Both Hands or Both Feet or the Entire Sight of Both Eye	$ 20,000
One Hand and One Foot	$ 20,000
Either One Hand or One Foot and the Entire Sight of One Eye	$ 20,000
One Hand or One Foot or the Entire Sight of One Eye	$ 10,000

"Loss" means with regard to hands and feet, the total and permanent loss of function. The loss of four fingers shall constitute the loss of a hand. Loss of sight means loss of sight to the extent of legal blindness.

OPTIONAL $100,000.00 ACCI-DENTAL BENEFIT

By adding $8.50 to your premium payment, dental benefits will be extended to provide payment for the Usual and Reasonable Expenses incurred within two years from the date of a covered accident for injury to sound and natural teeth to a maximum of $100,000 per covered accident, provided treatments and services begin within 90 days from the date of the covered injury. The following services are included in this benefit:

1. Replacement of caps, crowns, dentures, and orthodontic appliances (including braces) fillings, inlays, crozat appliances, endodontics, oral surgery, examinations and x-ray services required as a result of Injury.
2. In no event shall the Company's payment exceed the usual and reasonable charge normally made by a Dentist for necessary treatment actually rendered during the 104-week period immediately following the date of Injury; if there is more than one way to treat a Dental problem, the Company will pay benefits for the least expensive procedure provided that this meets acceptable dental standards.
3. When a dentist certifies to the Claim Administrator that treatment will continue beyond the two year benefit period, an additional $1,500 will be paid. Treatment must be completed within two years of the expiration of the initial benefit paying period. This benefit is in effect 24 hours a day, even when purchased with School Time Accident Coverage.

IMPORTANT NOTICE

This Brochure provides a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the policy issued in Pennsylvania under form number AH-17593-PA in which the policy was delivered. Complete details are found in the policy on file at your school's office. The policy is subject to the laws of the state in which it was issued. Please keep this information for your reference.

ACCIDENT INSURANCE PROTECTION PROVIDING A MAXIMUM OF $1,000,000 ACCIDENT MEDICAL EXPENSE BENEFITS

The company will pay the Usual and Reasonable Expenses incurred for a covered Injury, if first treatment is received within 90 days after the Injury. The Schedule of Benefits is stated below. Benefits are payable up to a maximum of 52 weeks after the date of the covered Injury.

MAXIMUM BENEFITS

Hospital Services:

Daily Room & Board (Semi-private) . . . . . Usual & Reasonable
Intensive Care Room & Board. . . . . Usual & Reasonable
(not to exceed 7 days)

Miscellaneous Services:

During Hospital Confinement or when
surgery is performed . . . . . Usual & Reasonable
Emergency Room out-patient:
when Hospital Confinement is not required. . . . . $400.00 maximum

Doctor's Services:

Surgery, including pre and post
operative care - Usual & Reasonable
Expenses in accordance with the
1974 Revised California Relative Value
Study, 5th Edition, having a conversion
factor of . . . . . $180.00 unit value
Anesthesia: (including administration)
and assistant surgeon: % of
surgical allowance. 40%
Doctor visits other than for Physiotherapy
or similar treatment when no surgery
benefit is paid . . . . . Usual & Reasonable
Consultants (when required by attending
physician for confirmation or determining
a diagnosis, but not for treatment) and
second opinion: . . . . . Usual & Reasonable

Laboratory & X-Ray Services:

Other than Dental and including fee
for interpretation and/or reading of . . . . . X-Ray - $650.00
X-ray when not Hospital Confined. . . . . Lab - $650.00

Additional Services:

Physiotherapy or similar treatment:
In-Hospital . . . . . Usual & Reasonable
Maximum 10 visits
Out of Hospital . . . . . $50 per visit
Maximum 10 visits
Registered or Licensed Nurse (in or
out of the hospital) . . . . . .Usual & Reasonable
Ambulance to initial treatment facility . . . . . Usual & Reasonable
Orthopedic Appliances:
In-Hospital . . . . . .Usual & Reasonable
Out of Hospital . . . . . .Usual & Reasonable
Outpatient drugs & medication: Administered in
Doctor's office or by prescription: . . . . . Usual & Reasonable
Eyeglasses, contact lenses and hearing aids;
replacement of broken eyeglasses and/or frames,
contact lenses, hearing aids, resulting from a
covered Injury . . . . . Usual & Reasonable

Dental Services:

For treatment, repair or replacement of Injured
natural teeth, includes initial braces when
required for treatment of a covered Injury, as well as
examinations, x-rays, restorative treatment,
endodontics, oral surgery, and treatment for gingivitis
resulting from trauma . . . . . Usual & Reasonable

PRIMARY EXCESS COVERAGE

The Company will pay the first $100 of covered expense for any one claim resulting from any one covered accident without regard to other insurance. Thereafter, benefits will be payable for covered expenses above $100.00 that are not recoverable from other valid and collectible group insurance. If the Insured is not covered by other insurance, full benefits will be payable as described in the Schedule of Benefits. Benefits are payable for a maximum of 52 weeks.

EXCLUSIONS AND LIMITATIONS

Exclusions apply to the Accident Medical Expense Benefit and the Accidental Death and Dismemberment Benefit.

The Policy does not cover any Loss incurred as a result of: (1) service or treatment rendered by a Physician, nurse, or any other person who is [a] employed or retained by the school; or [b] who is the Insured or a member of his/her Immediate Family; (2) charges which [a] the Insured would not have to pay if he/she did not have insurance; or [b] are in excess of Usual & Reasonable Expenses; (3) Intentionally self-inflicted Injury or suicide; Injury caused by war or any act of war; or Injury caused by taking part in a riot or civil disturbance; (4) Any Injury that is caused by: [a] flying in aircraft, except as a fare paying passenger; [b] parachuting; [c] travel in or upon a snowmobile or any two or three wheeled motorized vehicle or any off road motorized vehicle not requiring licensing as a motor vehicle; (5) any Injury for which the Insured is covered under Worker's Compensation or Employer's Liability Law; (6) that part of medical expenses payable by any automobile insurance policy without regard to fault (does not apply in any state that prohibits such limitation); (7) the Insured's part in committing or attempting to commit an unlawful act; (8) an Injury that is: [a] the result of the Insured being intoxicated: or [b] caused by use of any narcotic unless administered by or upon the advice of a Physician; (9) a sickness or disease; or Diagnostic Test or treatment, except infection which occurs directly from an accidental cut or wound; or ingestion of contaminated food; (10) Injuries sustained as a result of taking part in Senior High Interscholastic Football and/or Senior High Interscholastic Sports, including traveling to and from games and practice, unless specifically provided for in the school's master application;(11) expenses incurred in connection with plastic or cosmetic surgery or procedures unless required by an Injury which occurred while the Insured was covered; (12) any Injury resulting from participating in or practice for non-school sponsored skiing, ice hockey, or snow-mobiling; (13) eye-glasses, contact lenses, eye refractions or prescription therefore, except for the usual and reasonable charge for replacement of broken eyeglasses, broken frames or broken lenses resulting from a covered accident. Routine refraction and routine eye examinations are not covered under the policy.

LIMITATIONS: any Injury occurring, and expenses incurred therefrom, as a result of a covered accident which occurs while an Insured is engaged in an activity which is covered under the School's Compulsory Plan, will not be covered under a Voluntary Plan.
When Excess Insurance is provided and another Plan Providing Medical Expense Benefits to an Insured is an HMO, PPO, or similar arrangement for provision of benefits or services and the covered accident occurs within the geographic area of the HMO, PPO, or similar arrangement for provision of benefits or services and the Insured does not use the facilities of the HMO, PPO, or similar arrangement for provision of benefits or services, the medical benefits otherwise payable under the policy shall be reduced by 50%. This limitation shall not apply to emergency treatment required within 24 hours after an accident or when the covered accident occurs outside the geographic area served by the HMO, PPO, or similar arrangement of benefits or services.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims.

NOTE: It is not the intent of the Company to unfairly reduce benefit for any Insured if the Insured is outside the Network Area of the HMO, PPO, or similar arrangement for benefits or services and no benefits are available. The reduction of benefits is only for those Insureds who can use their HMO, PPO, or similar arrangement for benefits or services and have not done so.

To File A Claim:

1. To download a claim form, go to: www.amastudentplans.com/downloads/K-12_SR.pdf
2. Fill out parts A and B
3. Be sure to sign and date the bottom
4. Enclose any itemized bills or receipts from services rendered.
5. Send claim forms, itemized bills and receipts to:

MCA Administrators, Inc.
PO Box 6540
Harrisburg, PA 17112
(800) 427-9308

ENROLLMENT FORM CHECKLIST

Did You:

❒ Fill out all of the appropriate information on the enrollment form (MAKE SURE SCHOOL DISTRICT IS CLEARLY LISTED)

❒ Check the appropriate box(s) for the coverage you have selected.

❒ Enclose a CHECK or MONEY ORDER for the total Premium (your cancelled check or money order stub will serve as proof of payment) along with the completed enrollment form in an envelope.

For questions, inquiries, and information contact:

American Management Advisors, Inc.
PO Box 366
Langhorne, PA 19047
(888) 533-7654
(215) 946-8888

DO NOT SEND CASH

Enrollment Form

Please Print **Pennsylvania 2013-2014**

STUDENT'S LAST NAME

STUDENT'S FIRST NAME MIDDLE INITIAL

BIRTH DATE (MM/DD/YYYY) GRADE PHONE

HOME ADDRESS APT#

CITY ST ZIP

SCHOOL SYSTEM/DISTRICT

SCHOOL NAME

Any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form 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 act, which is a crime and subjects such person to criminal and civil penalties.

SIGNATURE OF PARENT OR GUARDIAN DATE

My signature above certifies that I have read and understand the Student Accident Insurance Protection brochure and agree to accept the terms and conditions stated herein.

No obligation to purchase.

School Year Rate – CHECK ✓ YOUR SELECTION

Coverage Plans	Premiums
BEST BUY! 24-Hour	☐ $116.00
School Time	☐ $30.00
Dental Accident Insurance (with either of the above plans)	☐ $8.50

Make checks payable to:

American Management Advisors, Inc.

How to Enroll

1. Decide whether you want the School time, 24-Hour Accident Protection or Dental Plan.
2. Fill out the enrollment form and enclose the form along with a check or money order made payable to the Administrator shown for the correct amount.
3. Mail envelope to American Management Advisors – PO Box 366 – Langhorne, PA 19047. Your cancelled check or money order stub will be your receipt and confirmation of payment. (Please write the student's name and school name on your check.)

MEDICAL CLAIM FORM

1. COMPLETE THIS FORM
2. ATTACH ALL BILLS
3. MAIL TO →

MCA ADMINISTRATORS, INC.

P.O. BOX 6540
HARRISBURG, PA 17112

ADMINISTRATOR FOR AMERICAN MANAGEMENT ADVISORS
UNDERWRITTEN BY: ACE AMERICAN INSURANCE COMPANY

CLAIM ASSISTANCE:
1-800-427-9308

IF PART A AND PART B ARE NOT COMPLETED *IN FULL* THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED.

BEFORE COMPLETING THIS FORM REFER TO CLAIM PROCEDURES AS THEY APPEAR ON THE BACK OF THIS MEDICAL CLAIM FORM

PART A. POLICY HOLDER

(1) Name of School District/College/Organization	Individual School/Team	(2) County

(3) Address of School: (Street)	(City)	(State)	(Zip)	(4) Area Code - Telephone #	(5) Date of Injury MO DAY YR

(6) Name of Injured Person	(7) Date of Birth MO DAY YR	(8) Social Security #	(9) Age	(10) Grade	(11) MALE ☐ FEMALE ☐

(12) Injury occurred: Practice ☐ Game ☐ P.E. ☐ Travel ☐ Classroom ☐ At Home ☐ Intramural ☐ Interscholastic ☐ Intercollegiate ☐

(13) Type of Sport:

(14) Describe in detail HOW the injury occurred. NOTE: If your school uses an accident report form, please attach a copy of the report.

(15) What part of the body was injured:
(Left or Right side if applicable)

(15a) Time of injury ____:____ a.m. ____:____ p.m.

(16) At the time of the accident, was the injured person involved in an activity under the jurisdiction of the policyholder? Yes ☐ No ☐

(17) Name of Supervisor (If different from organization official)

(18) Was he/she a witness to accident? Yes ☐ No ☐

(19) Signature of School or Organization Official	(20) Title of Official	(21) Date Signed MO DAY YR

PART B. PARENT, RESPONSIBLE PARTY OR GUARDIAN STATEMENT

(1) Name of Mother/Father or Guardian	(2) Social Security #	(3) Relationship to insured ☐ Father ☐ Mother Guardian Self

(4) Address (Number) Street (Lot or Apt. No.)	(5) City	(6) State	(7) Zip Code

(8) Area Code – Home Telephone Number

(9) Father's work telephone ( ) _____
Mother's work telephone ( ) _____

(10) Occupation of Father or Mother, Wife or Husband	(11) Place of Employment	(12) Address of Employer

(13) Occupation of Self (if over age 18)	(14) Place of Employment	(15) Address of Employer

(16) Do you have any other health and/or accident insurance plan (other than this plan?)
Father: ☐ YES ☐ NO Mother: ☐ YES ☐ NO Husband: ☐ YES ☐ NO Wife: ☐ YES ☐ NO Self: ☐ YES ☐ NO

(17) Is the injured person covered by other health and/or accident insurance plan?
☐ YES ☐ NO Effective Date MO DAY YR

(18) Name of other health and accident insurance company

(19) Address of Insurance Company	(20) Policy Number	Phone #

BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, government agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representative any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person who death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administration to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage the Policy identified above and that a copy of this Authorization shall be considered as valid as the original.
I agree that a photographic copy of this authorization shall be valid as the original.
I understand that I or my authorized representative may request a copy of this authorization.
I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to intent to revoke.

Signature of Insured or Authorized Representative — Dated

Address

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I authorize payment of Medical payments to Physician or Supplier for Services described on the reverse side and/or attached.

Date — Signature of Responsible Party or Student if 18 years old

Fraud 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.

CLAIM PROCEDURES

1. Submit all itemized bills to both your family insurance carrier and the insurance carrier for your school/organization. These bills are generally a HICFA form (Physician) or a UB92 form (Hospital). The Physician or Hospital has an assignment of Benefits on file; which was completed on the initial treatment visit. This assignment of Benefits will be honored. If your Provider does not bill on a HICFA or UB92 Form, You will need to sign the authorization to pay Benefits to the Provider on the front of this form.

2. If your family insurance carrier is an HMO organization, CONTACT YOUR HMO PHYSICIAN AT ONCE. FAILURE TO DO SO MAY RESULT IN THE CLAIM BEING DENIED OR A SUBSTANTIALLY REDUCED BENEFIT.

3. Your family insurance carrier will send you an Explanation of Benefits (E.O.B.) listing the payments made by them. Upon receipt of the E.O.B., forward the E.O.B. along with any unpaid itemized bills and a completed claim form to the claim administrator: MCA Administrators, Inc. for processing: paid receipts and/or balance due statements are not accepted.

4. If you do not have other valid and collectible insurance (Auto, Employer Provided, Family Insurance or Self-Provided): complete the information on the claim form, sign where indicated, include all your itemized bills, receipts, etc., and forward to the claim administration for processing.

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files a 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 subjects such person to criminal and civil penalties.

THINGS TO REMEMBER

1. TO SUBMIT ADDITIONAL BILLS AFTER THE ORIGINAL FORM HAS BEEN SENT IN, BE SURE TO INCLUDE THE FOLLOWING: (A) NAME OF CLAIMANT; (B) DATE OF ACCIDENT; (C) NAME OF THE POLICYHOLDER (SCHOOL, COLLEGE OR ORGANIZATION).

2. IF YOUR FAMILY INSURANCE CARRIER IS AN HMO ORGANIZATION, CONTACT YOUR HMO PHYSICIAN AT ONCE.

3. PROOF OF LOSS IS REQUIRED WITHIN 90 DAYS FROM THE DATE OF THE ACCIDENT. YOU HAVE ONE YEAR FROM THE TIME PROOF OF LOSS WOULD HAVE BEEN REQUIRED TO FILE A CLAIM. CLAIMS SUBMITTED PAST THIS PERIOD WILL NOT BE CONSIDERED FOR PAYMENT UNDER THE POLICY.

4. AUTHORIZATION TO RELEASE MEDICAL INFORMATION (MUST BE SIGNED)

5. PAYMENT WILL BE MADE TO THE SOURCE OF SERVICE (HOSPITAL, PHYSICIAN, ETC.) UNLESS CLAIM FORM ACCOMPANYING THE BILL INDICATES OTHERWISE AT THE TIME THE CLAIM IS SUBMITTED. IF YOU PAID FOR THE SERVICES AND REIMBURSEMENT IS TO BE PAID TO YOU, PROOF OF PAYMENT WILL BE REQUIRED AT THE TIME THE CLAIM IS SUBMITTED.