

Claim Serial Number (for office use only)



Guarantee Trust Life Ins. Co.
administered by
First Agency
5071 West H Avenue
Kalamazoo, MI 49009-8501

ACCIDENT CLAIM FORM

PARENT/GUARDIAN (OR CLAIMANT, IF AN ADULT) TO COMPLETE
ALL INFORMATION MUST BE COMPLETE OR CLAIM CANNOT BE PROCESSED

ACCIDENT CLAIM FORM

Part 1 – POLICYHOLDER TO COMPLETE

Policy Number: _____ Phone Number of Policyholder, including area code: (____) ____ - _____

Name of Policyholder or Organization: _____

Address of Policyholder: _____
(Street) (City) (State) (Zip)

Name of Injured Person: _____ Male Female Alternate Name: _____

Date of Birth: ____ - ____ - ____

Date of Injury: ____ - ____ - ____ Time of Injury: ____: ____ AM PM Type of Sport/Activity: _____

If a Sport, where did the injury occur: Practice Game Travel Other **If Other, please describe:** _____

How did the injury occur? (If your Organization uses an accident report form, please attach a copy of the report.) _____

Nature of Injury: _____

At the time of the accident, was the injured person involved in a sport/activity under the supervision of the Policyholder? Yes No

Was he or she a witness to the accident? Yes No Name of Supervisor/Official: _____

Signature of Organization Official _____ Date: _____ Title of Official: _____

Part 2 – PARENT/GUARDIAN (OR CLAIMANT, IF AN ADULT) TO COMPLETE

Name of Parents or Guardian: Mother: _____ Father: _____

Address: _____
(Street) (City) (State) (Zip)

Mother's Employer Name and Address:

Father's Employer Name and Address:

DO YOU HAVE ANY OTHER INSURANCE, which covers this condition, including Group, Individual Health and/or Accident or Motor Vehicle? Yes No If Yes, please give the other Policy Number: _____
Name of the Company and Phone Number: _____

I understand that this information will be used by First Agency for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief.

Parent/Guardian (or Claimant, if an adult): Signature: _____ Date: ____/____/____



First Agency
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HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared for purposes of obtaining information to process a claim for benefits.

Policy / Certificate# _____

I, the undersigned, authorize any licensed physician, medical professional, hospital, clinic, or other medical-related facility, pharmacies, pharmacy benefit managers, governmental agency, insurance company, insurance support organization, consumer reporting agency, group policyholder, employer or benefit plan administrator to provide First Agency or an agent, attorney, or independent administrator, acting on its behalf, all medical and health information concerning advice, care or treatment provided to the patient named below. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization excludes psychotherapy notes. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to First Agency, in care of the Claim Department Manager, at the above address. I understand that a revocation will not be effective to the extent First Agency has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits.

I understand that First Agency may condition payment of a claim upon my signing this Authorization if the disclosure of information is necessary to determine the level or validity of the claim payment. Failure to sign this Authorization, or subsequent revocation of this Authorization, may impair the ability of First Agency to process your application or evaluate claims, and may be a basis for denying an application or claim for benefits; however, your ability to receive health care services will not be changed if you do not sign this Authorization.

Once information is disclosed to First Agency pursuant to this Authorization, the information will remain protected by First Agency in accordance with federal or state privacy laws. However, I further understand that if a person or entity who receives this information is not covered by federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulation.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

If this Authorization is signed by my authorized representative, that individual's authority to act on my behalf is described below.

 (Print Please) Name of Claimant: Date of Birth

 Signature of Parent/Guardian (or Claimant if an adult) Date

 (Please Print) Name of Authorized Representative, or Next of Kin

 Relationship of Authorized Representative or Next of Kin to Claimant

 Signature of Authorized Representative or Next of Kin Date

Dear Parent:

Our camp provides accident insurance coverage for all participants in our sports/academic camp activities. Outlined below is important information regarding this coverage. It is intended as a brief description for reference only, and is not the policy.

Only **ACCIDENTS** that occur in sponsored and supervised sports/academic camp activities are covered.

DEFINITION OF ACCIDENT:

An unexpected, sudden and definable event which is the direct cause of a bodily injury, independent of any illness, prior injury or congenital predisposition.

Conditions that result from participating in an activity do not necessarily constitute accidents. For example, illnesses, diseases, degeneration, conditions caused by continued stress to a particular area of the body, and existing conditions aggravated by an accident are not covered.

- A. This plan of insurance is **EXCESS ONLY**: It will not duplicate benefits paid or payable by any other insurance or plan including HMO's or PPO's.
- B. The policy will not cover expenses payable under the insured's HMO (Health Maintenance Organization), or PPO (Preferred Provider Organization). If the insured chooses not to use an authorized medical vendor (under HMO or PPO), the policy will only cover expenses incurred that it would have honored had the insured used the proper medical vendor.
- C. Medical treatment for a covered accident must begin within 60 days of that accident. Only expenses incurred within 52 weeks are considered. Benefits are determined on the basis of **REASONABLE AND CUSTOMARY** for the geographic location where services are performed.
- D. Specific exclusions of the policy include, but are not limited to, sickness, disease, or hernia in any form; non-prescription drugs; fighting; and orthotics not prescribed exclusively for rehabilitation (e.g., playing brace, mouth guard).
- E. A \$100 deductible, which may be satisfied by other valid collectible insurance or plan payments, will be applied to each claim.
- F. Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties.

Accidents must be reported to the camp official within 20 days. Proof of loss must be submitted to First Agency within 90 days after medical treatment ends. Questions regarding claim procedures may be directed to First Agency at 5071 West H Avenue, Kalamazoo, Michigan 49009 or 269-381-6630 or Fax 269-381-3055.

HOW TO FILE YOUR ACCIDENT CLAIM FORM:

- 1. Complete **ALL** blanks. If information is not applicable, indicate the **reason** it is not (e.g., deceased, unknown).
- 2. Attach all ITEMIZED bills (not balance due statements) for **MEDICAL EXPENSES ONLY**.
- 3. Include all worksheets, denials, and/or statements of benefits from your primary insurer. (Each charge must be processed by all other insurances/plans before they can be processed by First Agency)
- 4. If you are employed and no coverage is provided by your employer, **A LETTER OF VERIFICATION FROM YOUR EMPLOYER STATING THAT NO COVERAGE IS PROVIDED MUST BE SUBMITTED.**

- 5. **Mail within 90 days of the accident to:**
Guarantee Trust Life Ins. Co. administered by
First Agency
5071 West H Avenue
Kalamazoo, MI 49009-8501

Dear Insured: Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. Thank you.

Connecticut	Massachusetts	Nebraska	South Dakota
Georgia	Michigan	North Carolina	Utah
Hawaii	Missouri	North Dakota	Vermont
Iowa	Mississippi	Nevada	Wisconsin
Illinois	Montana	South Carolina	Wyoming
Kansas			

General Fraud Warning (to be used for above states only)

Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

Alabama – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska – A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona - For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island and West Virginia

– Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California – For your protection California law requires the following to appear on this form: Any person who knowingly presents 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 – 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 a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Delaware – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

District of Columbia – 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 – Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho – Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky – A 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.

Maine – It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Maryland – Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota – A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire – Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey – Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico – ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio and Oregon – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma – WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania – Any person who knowingly and with intent to defraud any insurance company or other person files 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.

Tennessee, Virginia and Washington State – 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.

Texas – 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.