

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



Administered By:  
**LEFEBVRE INSURANCE, LLC**  
850 Franklin Street, Wrentham, MA 02093  
(800) 451-9668

**2016-2017**

Underwritten By:  
**AXIS Insurance Company**

### 24 Hour Accident Coverage

Provides accident coverage for the full 24 hours of the day, not only during school hours, but also at home or on weekends, during vacation periods, at camp, anytime, anywhere when school is not in session. SEE EXCLUSIONS.

Full Time, Registered Student K-12,  
Teachers, Administrative and Other Personnel. . . . . \$50.00

### SCHOOL TIME ACCIDENT COVERAGE

Provides coverage while in attendance at school during the hours and on the days that school is in session. Includes traveling directly and without interruption to or from the Insured's residence and the school for regular school session, for such travel time as is required, but not to exceed one hour after school is dismissed, or if additional travel time on the school bus is required, coverage here under shall extend for such additional travel time as might be necessary. Participation in or attending an activity exclusively organized, sponsored and solely supervised by the school and while under the supervision of school employees. Travel is limited to school supervised transportation. SEE EXCLUSIONS.

Full Time, Registered Student K-12,  
  
Teachers, Administrative and Other Personnel. . . . . \$8.00

### CONDITIONS

The accident must be reported immediately to a school authority under the School Time Coverage. Under the 24 Hour Coverage report the accident to the school or Lefebvre Insurance (the address is below). You will receive a claim form which must be filed with the Company within 90 days after the accident. Covered Excess Expenses incurred within two years from the accident will be considered. A claim for those Covered Expenses must be submitted to the Company for payment as soon as reasonably possible, but no later than one year from the date of service. It is the parent's responsibility to file the claim form within 90 days.

#### Direct All Questions and Correspondence To:

**LEFEBVRE INSURANCE, LLC**  
**850 Franklin Street, Wrentham, MA 02093**  
**(800)451-9668**

This brochure is not a contract. It is simply an illustration of benefits. You may read the master policy at the school district office. You will not receive an Individual Accident Policy. Keep your cancelled check, as it is proof of purchase. DO NOT SEND CASH.

**Disclosure:** US insurance coverage is underwritten by AXIS Insurance Company. Coverage is subject to exclusions and limitations and may not be available in all US states and jurisdictions. Product availability and plan design features, including eligibility requirements, descriptions of benefits, exclusions or limitations may vary depending on local country or US state laws. This insurance provided limited benefits. Limited benefits are insurance products with reduced benefits and are not intended to be an alternative to or integrated with comprehensive coverage. Further, this insurance does not coordinate with any other insurance plans. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential benefits as set for the under the Patient Protection and Affordable Care Act.

### Optional \$50,000 Extended Dental Benefit

When this option is purchased, the basic dental benefit will be extended to provide for the Usual & Customary Charges for Dental Treatment of a Dental Injury expenses incurred within 2 years from the date of the Covered Injury. Also included in this benefit are the following:

1. Dental Treatment means 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 & Customary Charge normally made by a Dentist for necessary treatment actually rendered during the 104-week period immediately following the date of Covered 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. If the Insured's Dentist certifies, in writing to the Claim Administrator, that treatment must be deferred until after two (2) years from the date of the Accident, a maximum of \$800.00 will be paid. Deferred Treatment must be completed within two (2) years of the expiration of the Initial Treatment Period. No bills will be paid without written certification. Services must commence within 90 days from the date of the Covered Injury. This benefit is in effect 24 hours a day, even when purchased with School Time Coverage.

Full Time, Registered Student K-12,  
Teachers, Administrative and Other Personnel. . . . . \$8.00

This coverage cannot be purchased without School Time or 24 Hour coverage.

### Accidental Death & Dismemberment

When Injury shall result in any one of the following losses within 180 days from the date of accident, the company will pay for Loss of:

Life . . . . .	\$5,000
(\$15,000 for a death under the Sports Condition of Coverage)	
Both hands or both feet or the entire sight of both eyes . . . . .	\$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" of a hand or foot means complete severance through or above the wrist or ankle joint. "Loss" of sight of an eye means total and irrecoverable loss of the entire sight in that eye. "Loss" of thumb or index finger means complete severance through or above the metacarpophalangeal joint of both digits. If more than one Loss is sustained by an Insured as a result of the same accident, only one amount, the largest, will be paid.

### Effective & Termination Date

Coverage begins at 12:01 AM on the date the School receives a completed application and payment of premium. Otherwise, coverage begins on the day of receipt of the application and the first official day of school or the first official practice of interscholastic athletics / activities.

The coverage terminates on the date the Insured ceases to be a registered student or the termination date of the policy, whichever occurs first. If the student, teacher, or administrative employee moves or transfers to another Public or Parochial Day School, the student, teacher, or administrative employee will be covered at the new school until this policy expires. If the premium check is returned from the bank for any reason, the coverage is null and void.

All other coverages end when School begins regularly scheduled classes for the following School term.

# ACCIDENT INSURANCE PROTECTION

## PROVIDING A MAXIMUM OF \$1,000,000 MEDICAL EXPENSE

The company will pay Usual and Customary Expenses incurred for a covered Injury if treatment is received within 90 days after the Injury. The Schedule of Benefits are stated below. Benefits are payable for 104 weeks from the date of the Injury.

### MAXIMUM BENEFITS

#### Hospital Services:

Daily Room & Board (Semi-private) . . . . . Up to \$800/day  
 Intensive Care Room & Board . . . . . Usual & Customary not to exceed 7 days

#### Miscellaneous Services:

During Hospital Confinement or when surgery is performed . . . . . \$800/day  
 Emergency Room outpatient: when Hospital Confinement is not required . . . . . Usual & Customary

#### Doctor's Services:

Surgery, including pre and post operative care - Usual & Customary Expenses in accordance with the 1974 Revised California Relative Value Study, 5th Edition, having a conversion factor of . . . . . \$150.00 unit value  
 Anesthesia: (including administration) and assistant surgeon: % of surgical allowance . . . . . 25%  
 Doctor visits other than for physiotherapy or similar treatment when no surgery benefits paid . . . . . Usual & Customary  
 Consultants (when required by attending physician for confirmation or determining a diagnosis but not for treatment) and second opinion: . . . . . Usual & Customary

#### Laboratory & X-Ray Services:

Other than Dental and including fee for interpretation and/or reading of X-Ray  
 X-ray when not Hospital Confined X-Ray . . . . . Usual & Customary  
 Lab . . . . . Usual & Customary  
 MRI's, CAT Scans, Laser Treatments or similar procedures, including fee for interpretation and/or reading . . . . . \$800.00

#### Additional Services:

Physiotherapy or similar treatment:  
 In-Hospital . . . . . Usual & Customary  
 Out of Hospital . . . . . \$1,500.00  
 Chiropractic Services (in or out of hospital) . . . . . \$500.00  
 Registered Nurse (in or out of hospital) . . . . . Usual & Customary  
 Ambulance to initial treatment facility . . . . . Usual & Customary  
 Orthopedic Appliances:  
 In-hospital . . . . . Usual & Customary  
 Out of hospital . . . . . \$1,000.00  
 Outpatient drugs & medication  
 Administered by a Doctor . . . . . Usual & Customary  
 Eyeglasses, contact lenses and hearing aids; replacement of broken eyeglasses and/or frames, contact lenses, hearing aids, resulting from a covered Injury. . . . . \$650.00

#### 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 examination, x-rays, restorative treatment, endodontics, oral surgery, and treatment for gingivitis resulting from trauma . . . . . \$750/tooth

### FULL EXCESS COVERAGE

Benefits are payable for Medically Necessary covered expenses that are in excess of amounts payable under any Other Health Care Plan and are subject to the applicable Total Maximum for all Accident Medical Benefits. If the Insured is not covered by any Other Health Care Plan providing Accident Medical Benefits, the excess provision shall not apply, and benefits are payable to the total Maximum for all Accident Medical Benefits as shown in your Master Insurance Application.

### EXCLUSIONS AND LIMITATIONS

**Exclusions:** The policy does not cover any loss incurred as a result of:

#### Limitation for Motor Vehicle Accidents

Benefits will be paid for Covered Expenses incurred for treatment of Covered Injuries that result directly and independently of all other causes from a Covered Accident that occurred while the Insured Person was riding in or driving a Motor Vehicle. Benefits will not exceed the Benefit Limit shown in the *Schedule of Benefits*.

### EXCLUDED EXPENSES:

For the purposes of this Accident Medical Benefit, the following will not be considered Medically Necessary Covered Expenses unless coverage is specifically provided:

1. expenses payable by any automobile insurance policy without regard to fault.
2. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury.
3. examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses;
4. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay;
5. treatment of injuries that result over a period of time (such as blisters, tennis elbow, etc.), and that are a normal, foreseeable result of participation in the Covered Activity (does not apply to Voluntary Coverage) (does not apply if Expanded Sports Medical Coverage is Selected on the Master Application).

#### Common Exclusions:

1. intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
2. commission or attempt to commit a felony or an assault or to which a contributing cause was the Insured Person being engaged in an illegal occupation;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
5. flight in, boarding or alighting from an Aircraft, except as a passenger on a regularly scheduled commercial airline;
6. parachuting;
7. Travel in or on any off-road motorized vehicle that does not require licensing as a motor vehicle;
8. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or non directly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
9. A cardiovascular, event or stroke resulting, directly and independently of all other causes, from exertion, as verified by a Physician, while the Insured Person participates in a Covered Activity (does not apply to Voluntary Coverage) (does not apply if Expanded Sports Medical Coverage is Selected on the Master Application);
10. 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;
11. injuries compensable under Workers' Compensation law or any similar law;
12. the Insured Person's intoxication. The Insured Person is conclusively deemed to be intoxicated if the level in His blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether He is in fact operating a motor vehicle, when the injury occurs. An autopsy report from a licensed medical examiner, law enforcement officer's report, or similar items will be considered proof of the Insured Person's intoxication;
13. practice or play in Senior High Interscholastic Football and/or Senior High Interscholastic Sports, including travelling to and from games and practice, unless specifically provided for in the Master Insurance Application;
14. participation in any sports activity not specifically authorized, sponsored and supervised by the Policyholder, whether or not it takes place on the Policyholder's premises or during normal School hours, including snowboarding skiing and ice hockey;
15. benefits will not be paid for services or treatment rendered by any person who is:
  - a. employed or retained by the Policyholder;
  - b. living in the Insured Person's household;
  - c. an Immediate Family Member, including domestic partner, of either the Insured Person or the Insured Person's Spouse; or
  - d. the Insured Person.

### **To File A Claim:**

1. Use attached claim form
2. Fill out all necessary information
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**

**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.**

### **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:**

**Lefebvre Insurance, LLC  
850 Franklin Street  
Wrentham, MA 02093  
(800) 451-9668**

DO NOT SEND CASH

# Enrollment Form

Please Print

2016-2017 MA

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		
<p>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.</p>		
SIGNATURE OF PARENT OR GUARDIAN		DATE
<p>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.</p>		

No obligation to purchase.

<b>School Year Rate – 2016-2017 CHECK ✓ YOUR SELECTION</b>	
<b>Coverage Plans</b>	<b>Premiums</b>
24-Hour – Including Extended Dental	<input type="checkbox"/> \$58.00
24 Hour Only	<input type="checkbox"/> \$50.00
School Time Only – Including Extended Dental	<input type="checkbox"/> \$16.00
School Time Only	<input type="checkbox"/> \$ 8.00

Make checks payable to:  
**AXIS Insurance Company**

<b>How to Enroll</b>
<ol style="list-style-type: none"> <li>1. Decide whether you want the School Time, 24-Hour Accident Protection (with or without Dental).</li> <li>2. Fill out the enrollment form and enclose the form along with a check or money order made payable to AXIS Insurance Company shown for the correct amount.</li> <li>3. Mail envelope to Lefebvre Insurance, LLC. – 850 Franklin Street – Wrentham, MA 02093. 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.)</li> </ol>

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

PO Box 6540  
Harrisburg, PA 17112

(800) 427-9308

UNDERWRITTEN BY: AXIS INSURANCE COMPANY

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 <input type="radio"/> FEMALE <input type="radio"/>
(12) Injury occurred: Practice <input type="radio"/> Game <input type="radio"/> P.E. <input type="radio"/> Travel <input type="radio"/> Classroom <input type="radio"/>		(13) Type of Sport: At Home <input type="radio"/> Intramural <input type="radio"/> Interscholastic <input type="radio"/> Intercollegiate <input type="radio"/>				
(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 <input type="radio"/> No <input type="radio"/>						
(17) Name of Supervisor (If different from organization official)				(18) Was he/she a witness to accident? Yes <input type="radio"/> No <input type="radio"/>		
(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 <input type="radio"/> Father <input type="radio"/> Mother <input type="radio"/> Guardian <input type="radio"/> 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: <input type="radio"/> YES <input type="radio"/> NO    Mother: <input type="radio"/> YES <input type="radio"/> NO    Husband: <input type="radio"/> YES <input type="radio"/> NO    Wife: <input type="radio"/> YES <input type="radio"/> NO    Self: <input type="radio"/> YES <input type="radio"/> NO						
(17) Is the Injured person covered by other health and/or accident insurance plan? <input type="radio"/> YES <input type="radio"/> NO    Effective Date MO   DAY   YR		(18) Name of other health and accident insurance company				
(19) Address of Insurance Company			(20) Policy Number		(21) 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 of drugs and alcohol, to determine eligibility for benefit payments under the policy number identified above. I authorize the policyholder, employer or benefit plan administrator 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 of 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

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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 at the top of the claim form: **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, etc., and forward to the claim administration for processing.

# FRAUD WARNING

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NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

# THINGS TO REMEMBER

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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 THIS 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.

## 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 Massachusetts under form number BACC-001-0909. 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.



## **How to file a Medical Claim**

(For Special Risk, Sports, Campers, Youth Groups, and Participant Accident Insurance Policies)

Attached is a claim form for your accident policy.  
Please forward claims and questions to the following address:

**MCA Administrators, Inc**  
**P O Box 6540**  
**Harrisburg, Pa 17112**  
**1-800-427-9308**  
[Student-insurance@mcoa.com](mailto:Student-insurance@mcoa.com)

**Step 1: Submit a completed Notice of Claim (claim form) via either by mail or by facsimile.**

**The Participating Organization (not the Parent, Claimant or Agent) should:**

- Fully answer each item in Part I, The Participating Organization Report.
- Read the fraud warning statement on page 3 and sign the form where indicated in Part I.

**The Parent/Guardian or Adult Claimant should:**

- Fully answer each item in Part II, Other Insurance Statement.
- Review Part III, Authorizations
- Read the fraud warning statement on page 3 and sign where indicated on the bottom of the Claim Form.

**Step 2: Submit itemized medical bills for payment consideration to our office. If other insurance exists, include the other insurance company's corresponding Explanation of Benefits (EOBs).**

### **Helpful information for submitting claims and expediting payment.**

- A fully completed Claim Form is required for each accident/injury. Claims submitted with incomplete information will not be paid pending receipt of the missing information.
- The acceptance of a claim form by an Insurance company is not an admission of coverage
- Providers may wish to bill us directly. If they do, please ensure a completed claim form has first been submitted to our office.
- In order to ensure we receive complete claim information, we suggest providers submit standardized billing statements (called "UB-04" for hospital charges and/or a "CMS-1500" for Physician Charges).
- Unless proof of payment is submitted with the medical bill (a copy of the check, a medical bill that indicates the claimant has made all or partial payment or zero balance information) claim payment is generally sent directly to the medical providers.



1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
3. MAIL TO



**MCA Administrators, Inc**  
**P O Box 6540**  
**Harrisburg, PA 17112**

**Phone: 1-800-427-9308**  
**Student-insurance@mcoa.com**

**PART I – PARTICIPATING ORGANIZATION STATEMENT**

Policy Number:		Organization Name:		Event, Activity or Sport:	
Claimant's Name (Injured Person)		Social Security Number	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	E-Mail Address
Address of Injured Person and Best Contact Phone Number (Include Area Code)					
Date and Time of Accident		Place where Accident Occurred		The injured person was a: <input type="checkbox"/> Participant <input type="checkbox"/> Staff Member <input type="checkbox"/> Other	
Dental Claims	Indicate which Teeth were Involved in the Accident	Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial			
Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)				Did Injury Result in Death? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Describe How Accident Occurred – Provide All Possible Details					
Did Accident Occur (Check Yes or No for Each of the Following):					
A. During a participating organization sponsored & supervised, or sanctioned activity?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	
B. On activity premises?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	
C. While traveling directly and uninterruptedly to or from the activity?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	
D. During a participating organization practice?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	or competition? <input type="checkbox"/> YES <input type="checkbox"/> NO
Signature of Participating Organization Representative		Name and Title of Participating Organization Representative			Date

**PART II – OTHER INSURANCE STATEMENT**

Do you/spouse/parent have medical/health care or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer or other source?  YES  NO

If Yes, name of insurance company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Mother's (Guardian's) primary employer name, address & telephone: \_\_\_\_\_

Father's (Guardian's) primary employer name, address & telephone: \_\_\_\_\_

Are you eligible to receive benefits under any governmental plan or program, including Medicare?

YES  NO If yes, please explain: \_\_\_\_\_

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.

**PART III – AUTHORIZATIONS**

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. If not signed, please provide proof of payment.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to **AXIS Insurance Company** or its designated administrator. A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse **AXIS Insurance Company** to the extent of any amount collectible.

I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## FRAUD STATEMENTS

### Important Notice

- ***In General, and specifically for residents of 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.
- ***For Residents of Alabama:*** 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 restitution fines and confinement in prison, or any combination thereof.
- ***For residents of 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.
- ***For residents of the 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.
- ***For residents of Florida:*** 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.
- ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
- ***For residents of Maine, Tennessee, Virginia and Washington:*** 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.
- ***For residents of Oregon:*** 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 may be guilty of a crime and may be subject to fines and confinement in prison.
- ***For residents of Maryland :*** Any person who knowingly or 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.
- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- ***For residents of 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.
- ***For residents of New York:*** 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 five thousand dollars and the stated value of the claim for each such violation.
- ***For residents of Ohio:*** 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.
- ***For residents of 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.
- ***For residents of Pennsylvania:*** 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 subjects such person to criminal and civil penalties.