IMPORTANT: STUDENT ACCIDENT & SICKNESS AND COVID-19

These are incredibly difficult times for all of us. Young people have had their worlds turned upside down and leadership in schools everywhere are trying hard to develop the best mitigation/recovery plans they can. While it's impossible to predict the full impact that COVID-19 will continue to have on schools and families, we are certain that the damage to the economy will result in many, many more students' insurance status than was the case before the pandemic took hold.

This is why distribution of the enclosed brochures to each and every student is now more crucial than ever!

Any family may find their financial circumstances changed overnight and should be informed of these coverage options for their children.

We want to point out that our **Student Accident & Sickness Plan**, covers sickness as well as injuries 24/7, providing reimbursement for most services and supplies at 80% of UCR up to $50,000/sickness and $200,000/injury after a small $50 deductible. This plan has been gaining considerable attention from both parents and districts from all across the country.

Our agreement with the School District requires that the families of each student receive the Student Accident & Sickness brochure at the beginning of the school year. We thank you for your cooperation in complying with this requirement.

Should you have any questions, please feel free to contact our staff anytime.

Sincerely,

Tony Soto
Director of Fulfillment | Myers-Stevens & Toohey
(800) 827-4695

This shipment includes the following materials:

- Short-Term 24/Hour Coverage Request Form
- Claim Instructions
- Claim Form
- 2020-2021 Student Accident & Sickness Brochures

1. LAST YEAR'S SUPPLIES

- Please be sure to discard all materials from years prior to 2020-2021. Materials from past years should not be handed out to students as they are inaccurate and will result in a delay of coverage.

2. DISTRIBUTION OF BROCHURES

Please Note: It is very important that every student in your school receive a Student Accident & Sickness Brochure.

- These may also be included in registration paperwork or a "Welcome Back to School" mailing prior to the start of school. They may also be distributed by teachers in class for students to take home during the first week of school.
- Students who enroll in school late should be given the materials whenever they register.
- Students may apply for the insurance anytime during the school year, however, early enrollment is encouraged.

3. ENROLLMENT PROCEDURE

- Your school has been provided with our "Mailback" Brochures that describe the coverage, benefits, provisions, and enrollment instructions. Attached to the brochure is the Enrollment Form so that parents may return this form, with the appropriate premium, directly to Myers-Stevens & Toohey & Co., Inc.
- The Mailback Brochure has a conveniently attached self-mailing envelope but parents may also send us a fax or for IMMEDIATE processing enroll online at www.myers-stevens.com.

Additional claim forms may be downloaded at *www.myers-stevens.com* or mailed upon request.

ALL PLANS ARRANGED & ADMINISTERED BY:

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SHORT-TERM (24-HOUR) COVERAGE
Accident Insurance Enrollment Form for the 2020-2021 School Year
100% Participation Required

Provides excess accident and emergency sickness medical coverage and accidental death and dismemberment coverage for all of your students participating in school sponsored and supervised activities involving overnight travel and/or periods without direct and immediate school supervision. Rate is $1.85/person/calendar day. Coverage consists of BASIC and CATASTROPHIC injury benefits.

Basic	Accident medical benefits are paid on an excess basis at 100% of Usual and Customary charges up to $25,000/injury and up to $1,000 for Emergency Sickness ("Emergency Care Benefit" in IN, KS, and MO). Includes benefit for pre-approved Medical Evacuation expenses up to $25,000 and up to $10,000 of expenses for Repatriation of Remains to home country. Covered charges for injuries are limited to those incurred within one year from date of first treatment and Emergency Sickness benefits are limited to those charges incurred within 24 hours from the onset of sickness.
Catastrophic	Benefits are subject to a deductible of $25,000 and are then paid at 100% of Usual and Customary Charges up to $1,000,000. Includes additional cash benefits of up to $500,000 (depending upon the severity of the loss) and accidental death benefit of $25,000.

Underwritten by ACE American Insurance Company
The policies have complete details of provisions, limits and exclusions.

APPLICATION AND LIST OF NAMES

MUST BE RECEIVED BY MYERS-STEVENS PRIOR TO THE START DATE OF ACTIVITIES, OTHERWISE COVERAGE WILL BEGIN UPON RECEIPT. PREMIUM IS DUE WITHIN 10 DAYS OF THE START OF THE ACTIVITY. It is required that all students attending this event are covered, whether they have other insurance or not.

Coverage is optional for parent volunteers and other youth participants. Staff may also be included on an optional basis. Please include names with list of students on reverse.

Please complete the entire form below and the list of names on the reverse side. Return with your premium or billing information.

Mail or fax to: Myers-Stevens & Toohey & Co., Inc. - 26101 Marguerite Parkway Mission Viejo, CA. 92692-3203 • Via Fax – (949) 348-0963

QUESTIONS??? Call (800) 827-4695

ACTIVITY INFORMATION

Name of District _____

Name of School _____

Address _____ Phone _____

E-mail Contact _____

Starting date _____ Ending Date _____

Destination/Activity _____

Coverage requested by:

_____ _____ _____
Print Name Signature Date

PLEASE NOTE: THERE IS A MINIMUM PREMIUM REQUIREMENT.
Premium is due within 10 days of the start date of activity.

PAYMENT/BILLING INFORMATION

NEW ( ) REVISED ( )

Calculate Premium Due: _____ x _____ x $1.85 = $ _____
# of Participants # of Calendar Days Premium Rate PREMIUM DUE ($35 minimum)

METHOD OF PAYMENT: ( ) REQUEST INVOICE ( ) NO INVOICE NEEDED ( ) P.O. NUMBER _____

If paying by credit card, complete below. Your amount of charge will appear as "MYERS-STEVENS & TOOHEY 800-827-4695 CA" on your statement.

MC/VISA AUTHORIZATIONS: MC: ( ) VISA: ( ) _____ - _____ - _____ - _____

_____ _____ _____
Month / Year Security Code Zip Code of Cardholder

I authorize Myers-Stevens & Toohey & Co., Inc. to deduct the premium payment:

Name of Cardholder _____ Cardholder's Signature _____

SHORT-TERM (24-HOUR) COVERAGE

LIST OF STUDENTS / PARENT VOLUNTEERS AND OTHER YOUTH PARTICIPANTS / STAFF

Please provide names below. If necessary, please make copies and attach separately.

Name of School _____

Name and location of activity _____

Starting date _____ Ending Date _____

Students

	Last Name	First Name		Last Name	First Name
1.			26.		
2.			27.		
3.			28.		
4.			29.		
5.			30.		
6.			31.		
7.			32.		
8.			33.		
9.			34.		
10.			35.		
11.			36.		
12.			37.		
13.			38.		
14.			39.		
15.			40.		
16.			41.		
17.			42.		
18.			43.		
19.			44.		
20.			45.		
21.			46.		
22.			47.		
23.			48.		
24.			49.		
25.			50.		

Parent Volunteers and Other Youth Participants

Last Name	First Name

Staff

Last Name	First Name

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Student Accident & Sickness Insurance
CLAIM FILING INSTRUCTIONS

FOR PARENTS/LEGAL GUARDIANS (or students of legal age)

Coverage terms and conditions

Prior to an injury or sickness occurring or as soon as possible thereafter, please familiarize yourself with the terms and conditions of coverage including: what activities are covered; benefits; exclusions; requirements and limitations; important deadlines, etc. These may be found in policies on file with school/parish authorities, printed brochures used to secure coverage, online or by contacting us directly at (800) 827-4695.

Claim form and reporting

Report school/parish related injuries immediately to school officials, providing as much detail as possible.

Request a Student Accident & Sickness Insurance claim form from the school/parish and ask an authorized school/parish official to COMPLETELY AND LEGIBLY fill out Part A of the form. If the reported injury is not school/parish-related, you may fill out Part A yourself. Only one claim form is required per injury or condition.

COMPLETELY AND LEGIBLY fill out Part B (missing fields will cause delays) provide signatures where requested, date and return to our office along with your itemized bills and Explanations of Benefits (EOBs) from any other applicable insurance or health plan.

Finding a health provider

You are free to take your child to any properly licensed health provider but out-of-pocket costs may be reduced if you seek care from providers who are contracted under the *First Health Network* or *First Choice Health Network* (WA only). Contracted providers may be found at www.firsthealth.com (800) 226-5116 or www.fchn.com (800) 231-6935. If your child also has coverage through an HMO, please know that benefits under many of our school/parish-paid blanket plans may be reduced if you seek out-of-network services that are not preauthorized by your HMO. This potential benefit limitation does not apply to any of our individually purchased plans and does not apply to emergency care.

When treatment is sought

Give the provider's billing/admissions person your primary insurance/health plan information (if applicable).

If you purchased one of our individual plans for your child, present your student insurance ID Card. If your child is covered under a blanket plan that is paid for by the school/parish, let the billing person know that and identify the district, Diocese or other school system involved and the specific school/parish. In either case, explain that your child's coverage is "secondary accident medical expense insurance" or accident & sickness insurance and that it is NOT what is sometimes referred to as "third party" insurance. Your child is the insured.
Ask the billing person to add Myers-Stevens & Toohey into their system as a payor and to either send us the itemized bills described above directly (preferred!) or to send you those same bills to be forwarded to us. Letting the provider know that you are assigning benefits to them may help smooth the process. If you have difficulty, please contact us and we'll be happy to help.

If your child has other insurance or health coverage

File a claim with that primary plan (except Medicaid) and send us copies of their "Explanation of Benefits" or "EOBs" once processed.

What we need from the providers who see your child*

In order to evaluate your claim and provide benefits, we will need fully itemized bills from any providers seen. These are known as HCFA 1500 or CMS 1500 forms from providers such as doctors and as a UB04 form from facilities such as hospitals and surgery centers. They contain the following required information:

- Date(s) of Service
- Billed Charges
- Diagnostic Codes - these tell us what is wrong with your child
- Procedural or Revenue Codes - these tell us what was done to evaluate/treat the problem
- Provider Tax ID Number - needed to issue W-9s when benefits are assigned to providers
- National Provider Identifier (NPI) - needed to comply with Federal regulations

NOTE – we are not able to use "statements" from providers, primary health plan EOBs or a receipt of payment in lieu of the required itemized billings as described above.

**If you have Kaiser, request "courtesy statements" from Kaiser Member Services that include the information listed above. Please make sure the documentation submitted indicates what portion of the charges, if any, you are obligated to pay out of your own pocket.*

Final Steps

Send: 1) Completed claim form; 2) Itemized bills; 3) Other insurance/health plan EOBs (when applicable) to:

MYERS-STEVENS & TOOHEY
Attn: Claims Department
26101 Marguerite Parkway
Mission Viejo, CA. 92692

OR **Fax: (949) 348-9350** *OR* **Email: claimsinfo@myers-stevens.com**

Need more help? Call us at (800) 827-4695

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STUDENT ACCIDENT & SICKNESS INSURANCE CLAIM FORM

PART A SCHOOL/PARISH STATEMENT

(Parent or legal guardian may complete Part A if injury is not school/parish-related)

NAME OF CLAIMANT FIRST	MI	LAST	AGE	GRADE	☐ FEMALE ☐ MALE	DATE OF BIRTH MO / DAY / YR

ADDRESS OF CLAIMANT | CITY | STATE | ZIP CODE

IS THE CLAIMANT A: ☐ STUDENT ☐ STAFF ☐ VOLUNTEER ☐ OTHER _____

ID # FROM ID CARD (if applicable)

NAME OF SCHOOL/PARISH

NAME OF DISTRICT, DIOCESE OR OTHER SCHOOL SYSTEM

SCHOOL/PARISH MAILING ADDRESS | CITY | STATE | ZIP CODE

DURING WHAT ACTIVITY DID THE INJURY OCCUR? ☐ INTERSCHOLASTIC PRACTICE ☐ INTERSCHOLASTIC GAME ☐ P.E. ☐ CLASSROOM ☐ PLAYGROUND ☐ TRAVEL ☐ AT HOME ☐ FIELD TRIP ☐ RELIGIOUS EDUCATION ☐ CONFIRMATION ☐ YOUTH MINISTRY ☐ YOUNG ADULT MINISTRY ☐ CYO ☐ PAL ☐ OTHER _____

WAS THE CLAIMANT PARTICIPATING IN A SPORT NOT SCHOOL/PARISH-SPONSORED AND SUPERVISED? ☐ YES ☐ NO
IF YES, LIST NAME OF SPORTS ORGANIZATION:

TYPE OF SPORT:

DOES THE SCHOOL/PARISH HAVE ANY RECORD OF ANY HEALTH COVERAGE FOR THE CLAIMANT? ☐ YES ☐ NO
If YES, name of plan:

DATE OF INJURY/SICKNESS MO / DAY / YR

TIME OF INJURY : (CIRCLE ONE)

WHAT **PART** OF THE BODY WAS INJURED? ☐ LEFT ☐ RIGHT

HAS THE CLAIMANT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? ☐ YES ☐ NO IF YES, WHEN?

PROVIDE DETAILS ON HOW AND WHERE THE INJURY OR ILLNESS OCCURRED. PLEASE BE SPECIFIC

NAME AND TITLE OF SUPERVISING OFFICIAL AT TIME OF INJURY

WAS HE/SHE A WITNESS TO THE ACCIDENT? ☐ YES ☐ NO

DATE SCHOOL/PARISH WAS NOTIFIED / /

NAME AND TITLE OF OFFICIAL COMPLETING FORM

SIGNATURE X

DATE SIGNED

SCHOOL/PARISH TELEPHONE NUMBER ( )

PART B PARENT OR LEGAL GUARDIAN INFORMATION

NAME OF CLAIMANT'S PRIMARY PHYSICIAN | ADDRESS | PHONE NUMBER ( )

IS THE CLAIMANT COVERED, DIRECTLY AND/OR AS A DEPENDENT UNDER ANY OTHER INSURANCE OR HEALTH PLAN(S)? ☐ YES ☐ NO
IF YES, NAME OF PLAN(S) | POLICY NUMBER(S)

NAME OF CLAIMANT'S EMPLOYER (if applicable) | ADDRESS | PHONE NUMBER ( )

NAME OF FATHER OR LEGAL MALE GUARDIAN | MOBILE TELEPHONE NO. ( ) | HOME TELEPHONE NO. ( )

ADDRESS | CITY | STATE | ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed | WORK TELEPHONE ( )

ADDRESS OF EMPLOYER | CITY | STATE | ZIP CODE

NAME OF MOTHER OR LEGAL FEMALE GUARDIAN | MOBILE TELEPHONE NO. ( ) | HOME TELEPHONE NO. ( )

ADDRESS | CITY | STATE | ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed | WORK TELEPHONE ( )

ADDRESS OF EMPLOYER | CITY | STATE | ZIP CODE

AUTHORIZATION: I hereby authorize any School, Participating Organization, Policyholder, trust, employer, insurance company, health plan, medical/dental provider or other person or entity to release any information/documentation needed to process this claim to Myers-Stevens & Toohey & Co., Inc. (MST) or its insuring company when requested by them to do so. This may include but is not limited to: details of the reported loss; identification of witnesses and supervisors; verification of other insurance or health coverage; coverage terms; explanations of benefits; complete health records including those involving mental/emotional disorders and substance abuse; prescription drug history and fully itemized bills in the form of CMS/HCFA 1500s and UB04s. If the claim is reportedly the result of participating in a School, Participating Organization or Policyholder activity, I authorize MST to share information concerning this claim as necessary with representatives of the School, Participating Organization or Policyholder as applicable. I understand that the authorization to release claim-related information/documentation to MST will terminate two years from the date of signature unless terminated in writing on an earlier date by me. A photo static/digital copy of this authorization shall be considered as valid and effective as the original.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE X _____ DATE _____

ASSIGNMENT OF BENEFITS: I authorize the payment of benefits directly to the provider(s) of services and/or supplies associated with this claim.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE X _____ DATE _____

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other persons, 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, subject to criminal prosecution and/or civil penalties.
I have read and acknowledge the General Fraud Warning above and the specific version for my state on the reverse side.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE X _____ DATE _____

STATE-SPECIFIC FRAUD WARNINGS

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, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment for 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 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.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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

Kentucky: 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.

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

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 R.S.A. 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.

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 $5,000 and the stated value of the claim for each violation.

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.

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 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.

Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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CA License #0425842

Underwritten by: ACE *American Insurance Company*

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PPO Network - ***WA***