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 TO COMPLETE

ALL INFORMATION MUST BE COMPLETE OR CLAIM CANNOT BE PROCESSED

Student's Full Name ____________________ Exact Date of Accident ____________________

Student's Date of Birth ____________________

FATHER	MOTHER
Father's Full Name ____________________	Mother's Full Name ____________________
Home Address ____________________	Home Address ____________________
City __________ State ______ Zip ______	City __________ State ______ Zip ______
Home Phone ____________________	Home Phone ____________________
Employer Name ____________________	Employer Name ____________________
Employer Address ____________________	Employer Address ____________________
City __________ State ______ Zip ______	City __________ State ______ Zip ______
Self Employed? ☐ YES ☐ NO	Self Employed? ☐ YES ☐ NO
PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:	PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:
Do you have insurance? ☐ YES ☐ NO Is this student covered? ☐ YES ☐ NO	Do you have insurance? ☐ YES ☐ NO Is this student covered? ☐ YES ☐ NO
Name of Insurance Plan ____________________	Name of Insurance Plan ____________________
Phone Number ____________________	Phone Number ____________________
Group Number ____________________	Group Number ____________________
If you are employed, but your dependent is not covered under your employer's plan, a letter to this effect from your employer is required.	If you are employed, but your dependent is not covered under your employer's plan, a letter to this effect from your employer is required.

AUTHORIZATION - To Permit Use and Disclosure of Health Information

First Agency
5071 West H Avenue
Kalamazoo, MI 49009-8501

This Authorization was prepared by First Agency for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. 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. If this Authorization is for someone other than myself, that individual has given me the authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have 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. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

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. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency in accordance with federal or state law.

I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This Authorization is valid from the date signed for the duration of the claim.

____
Name of Authorized Representative, or Next of Kin

____
Name of Claimant

____________________ __________
Signature of Authorized Representative or Next of Kin Date

____________________ __________
Signature of Claimant (If claimant is 18 or older) Date

____
Relationship of Authorized Representative or Next of Kin to Claimant

SCHOOL/ADMINISTRATOR/OFFICIAL/POLICYHOLDER TO COMPLETE

School Student Attends ____________________ in ____________________ School District

Student's Full Name (Last, First, MI): ____________________ Sex: ☐ Male ☐ Female Grade: ______

Student's Home Address: ____________________

Date of Accident: __________ Time of Accident: __________ ☐ AM ☐ PM

Detailed Description of Accident: How did it occur? (or attach accident report completed by the school representative who witnessed the accident) ____________________

____

Where did it occur? ____________________

Part of body injured: ____________________ ☐ Right ☐ Left

Activity: __________ ☐ Interscholastic ☐ Intramural ☐ Club ☐ Other (describe) __________

Name of school authority supervising activity: ____________________

Was supervisor a witness to the accident? ☐ Yes ☐ No If No, date reported to school: __________

Signature of School Official: ____________________ Date: __________ Title of School Official: __________

Dear Parent:

Our camp provides accident insurance coverage for all participants in our summer 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 summer 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. 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

Grand Valley State University Summer Camps/MI