Why is Each Student Required to Receive a Brochure?

Though more families in the U.S. are obtaining health coverage, there continues to be an increasing amount of coverage gaps in many of these plans. Other students may still be without insurance altogether. Uncovered costs for medical care following a school-related injury can be a serious problem for families and for schools!

This is why adequate distribution to each and every student is crucial. Whether or not the student participates in interscholastic sports, attends high school or grade school-- every family deserves a fair opportunity to make an informed decision when providing coverage for their children.

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. Below are several suggested distribution options:

Back-to-School Mailer:	Most schools find it easiest to include the brochure in these mailers.
First Day Packets:	Many schools send their students home with various First Day packets for their parents' review and our brochure may be included in this.
Direct Handouts:	If the above options aren't available then brochures may be distributed amongst teachers and simply handed out from teacher-to-student in a "homework" fashion during class. Students should be instructed to give the brochure to their parents.

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

Sincerely,

Tony Soto
Director of Fulfillment
Office: (800) 827-4695 *612
Email: tsoto@myers-stevens.com

New for 2018-2019:

Brochures available in 4 New Languages!

Both our Student Accident & Sickness and Worldwide Exchange brochures will be translated in the following languages and available in electronic format:

- ✓ *Chinese*
- ✓ *Korean*
- ✓ *Arabic*
- ✓ *Japanese*

Call or email for PDFs!
(800) 827-4695 | tsoto@myers-stevens.com

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SHORT-TERM (24-HOUR), COVERAGE

ACCIDENT INSURANCE ENROLLMENT FORM FOR THE *2018-2019* 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 the following BASIC and CATASTROPHIC injury benefits.

Basic

Accident medical benefits are paid on an excess basis of 100% of Usual, Customary & Reasonable charges up to $25,000/ injury and $1,000 for Emergency Sickness. 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 of the injury or sickness. Underwritten by BCS Insurance Company.

Catastrophic

Accident medical benefits are subject to a deductible of $25,000 and are then paid on an excess basis at 100% of Usual, Customary and Reasonable charges up to $1,000,000 with a ten year benefit period. Includes additional cash assistance 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.

Crisis Management Benefit.....$100,000 Maximum

If a student is killed as a result of criminal violence while participating in a Covered Activity sponsored and supervised by the School or school district, we will pay the Crisis Management Benefit shown in the Schedule of Benefits to the School or school district involved to help them access the counseling and other care they deem is needed by the student body and staff.

Cosmetic Disfigurement from Burns Benefit..... $150,000 Maximum

If, as a result of a Covered Injury, an Insured suffers third or fourth degree burns in one or more areas of the body, benefits will be paid as determined by the formula specified in the policy.

Special Adaptation Expense Benefit..... $75,000 Maximum

If an Insured suffers a "presumptive disability" from a covered Accident and requires a special housing adaptation or a special vehicle to accommodate the disability.

Traumatic Brain Deficit Benefit..... $250,000 Maximum

If an Insured suffers an injury to the brain which 1) occurs, and is diagnosed by a Doctor; 2) results in measurable, neurological deficit persisting for the lesser of at least 12 consecutive months or the time at which maximum recovery has been reached; 3) requires permanent daily personal supervision; and 4) results in the inability of the Insured to perform independently three or more of the following activities of daily living: a) transferring (moving in or out of a bed or chair); b) dressing; c) bathing; d) feeding; e) toileting; or f) continence.

The policies have complete details of provisions, definitions, limits and exclusions.

INSTRUCTIONS - Complete Enrollment Form on Reverse

The fully completed enrollment form and roster of participating students (and coaches/instructors) must be received by us 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.

Mail, fax or email to: Myers-Stevens & Toohey & Co., Inc. - 26101 Marguerite Parkway Mission Viejo, CA. 92692
Via Fax – (949) 348-2630 • Via Email – activities@myers-stevens.com

QUESTIONS??? Call (800) 827-4695

ENROLLMENT FORM

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: ( ) CREDIT CARD (see below) ( ) CHECK NUMBER _____ ( ) 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: ( ) _____ - _____ - _____ - _____ _____ _____

Month / Year Security Code

I authorize Myers-Stevens & Toohey & Co., Inc. to deduct the premium payment, plus a 3% processing fee:

Name of Cardholder _____ Cardholder's Signature _____

LIST STUDENTS / PARENT VOLUNTEERS & OTHER YOUTH PARTICIPANTS / STAFF

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

Students

	Last Name	First Name		Last Name	First Name
1.			14.		
2.			15.		
3.			16.		
4.			17.		
5.			18.		
6.			19.		
7.			20.		
8.			21.		
9.			22.		
10.			23.		
11.			24.		
12.			25.		
13.			26.		

Parent Volunteers and Other Youth Participants

Last Name	First Name

Staff

Last Name	First Name

SEE REVERSE SIDE FOR CLAIM FILING INSTRUCTIONS

1. Report school-related injuries to the school within 72 hours
2. Complete this form
3. Attach all bills
4. Mail to →

Myers-Stevens & Toohey & Co., Inc.
26101 marguerite parkway
mission viejo, california 92692-3203
office (800) 827-4695 · fax (949) 348-2630

STUDENT INSURANCE CLAIM FORM

PART A SCHOOL STATEMENT (PARENT OR LEGAL GUARDIAN MAY COMPLETE PART A IF INJURY IS NOT SCHOOL RELATED)

NAME OF INSURED PERSON FIRST MI LAST | STUDENT I.D. # FROM I.D. CARD

NAME OF SCHOOL | NAME OF SCHOOL DISTRICT | AGE | GRADE | ☐ FEMALE ☐ MALE | DATE OF BIRTH MO / DAY / YR

ADDRESS OF SCHOOL | CITY | STATE | ZIP CODE

DATE OF INJURY/SICKNESS MO / DAY / YR | TIME OF INJURY : A.M. / P.M. (CIRCLE ONE) | INJURY OCCURRED: PLEASE ✔ ONE ☐ Interscholastic Practice ☐ Interscholastic Game ☐ P.E. ☐ Classroom ☐ Travel ☐ At Home ☐ Field Trip ☐ Other_____ | TYPE OF SPORT

DETAILS OF SICKNESS OR HOW THE INJURY OCCURRED. **PLEASE BE SPECIFIC** | WAS STUDENT PARTICIPATING IN SPORT NOT SCHOOL-RELATED? (IF YES, LIST NAME AND PHONE NO. OF GROUP) ☐ YES ☐ NO

WHAT **PART** OF THE BODY WAS INJURED? | HAS THE STUDENT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? ☐ YES ☐ NO IF YES, WHEN?

NAME AND TITLE OF SCHOOL SUPERVISOR | WAS HE/SHE A WITNESS TO THE ACCIDENT? ☐ YES ☐ NO | DATE SCHOOL WAS NOTIFIED OF ACCIDENT

NAME OF SCHOOL OFFICIAL | SIGNATURE OF SCHOOL OFFICIAL X | DATE SIGNED | SCHOOL TELEPHONE NO. ( )

PART B PARENT OR LEGAL GUARDIAN STATEMENT *(PLEASE PRINT OR TYPE CLEARLY)*

IS THIS STUDENT COVERED BY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLANS?
☐ NO ☐ YES IF YES, NAME OF ORGINIZATION (S)

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

ADDRESS | CITY | STATE | ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed | WORK TELEPHONE AND EXTENSION NO. ( )

ADDRESS OF EMPLOYER | CITY | STATE | ZIP CODE

NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY THROUGH FATHER OR LEGAL MALE GUARDIAN | POLICY NUMBER | TELEPHONE NO. ( )

MAILING ADDRESS OF INSURANCE COMPANY | CITY | STATE | ZIP CODE

NAME, ADDRESS AND PHONE NO. OF STUDENT'S FAMILY PHYSICIAN | CITY | STATE | ZIP CODE | TELEPHONE NO. ( )

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

ADDRESS | CITY | STATE | ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed | WORK TELEPHONE AND EXTENSION NO. ( )

ADDRESS OF EMPLOYER | CITY | STATE | ZIP CODE

NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY OF MOTHER OR LEGAL FEMALE GUARDIAN | POLICY NUMBER | TELEPHONE NO. ( )

MAILING ADDRESS OF INSURANCE COMPANY | CITY | STATE | ZIP CODE

I understand that 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 facts material thereto commits a fraudulent act, which is a crime, and may subject such person to fines and/or imprisonment.
I hereby authorize any school authority, trust fund, employer, insurance company or person who has attended or examined the claimant to disclose to Myers-Stevens & Toohey & Co., Inc., when requested to do so, any information regarding any injury, illness, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills, and to pay benefits based upon this information. A photostatic copy of this authorization shall be considered as valid and effective as the original.

PARENT OR LEGAL GUARDIAN SIGNATURE X

RELATIONSHIP TO STUDENT | DATE

AUTHORIZATION TO PAY BENEFITS TO PROVIDER. I authorize payment of Medical payments to Physician or Supplier for Services on the attached.

SIGNATURE OF PARENT OR LEGAL GUARDIAN_____ DATE_____

CLAIM FILING PROCEDURE

1. Report school-related injuries to the school within 72 hours.
2. Have school complete PART A. (Parents or legal guardian may fill out PART A if injury is not school related.)
3. Claimant, parent or guardian complete PART B.
4. **IMPORTANT: Both parts must be completed in full or claim will not be processed.**
5. Mail form to our office with all itemized bills **within 90 days of the first date of treatment.**
6. At the same time, please file a claim with your other family health and/or accident carrier. This can include employee plans, union plans, CHAMPUS (military plans), service contracts, self-insured benefit plan, or health maintenance organizations (HMO's).
7. When you receive a notice of payment, a notice of denial, or a letter stating you have met your deductible from your other health and/or accident carrier, please forward this information to our office in a timely fashion to expedite the processing of your claim.
8. If you have any questions, please call our office at 800-827-4695.

NON-DUPLICATION OF BENEFITS: In order to keep premiums as affordable as possible, these plans pay benefits on a non-duplicating basis. This means, if a person is covered by one or more of our plans and by any other valid insurance or health agreement, any amount payable or provided by the other coverages will be subtracted from the covered expenses and we will pay benefits based on the remaining amount.

COMMONLY ASKED QUESTIONS

Q: Do I have to go to a specific doctor or hospital?

A: *No, you can go to the doctor or hospital of your choice. However, if you go to a provider within the provider network, you may have your out-of-pocket expenses significantly reduced. To find a participating provider in your area, call 800-226-5116 or log on to www.myfirsthealth.com. In Washington or Idaho, call 800-823-6935 or log on to: www.fchn.com.*

Q: Do I need to attach a claim form for each bill?

A: *No, only one claim form is required per injury or sickness.*

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Myers-Stevens & Toohey & Co., Inc.
26101 marguerite parkway
mission viejo, california 92692-3203
offfic (949) 348-0656
fax (949) 348-2630

First Health®

Underwritten by:
BCS

Underwritten by:
ACE American Insurance Company
CHUBB

First Choice Health
PPO Network
WA, ID

For residents of 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.

For residents of Oregon: WARNING: Any person who knowingly, and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud

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.