POINT PLEASANT SCHOOLS

Steven W. Corso, CPA
School Business Administrator/Board Secretary

2100 Panther Path
Point Pleasant, NJ 08742
(732) 701-1900, Ext. 2410
Fax: (732) 295-2320

RE: Student Accident Reporting

Dear Parent/Guardian:

This letter is to inform you of the instructions for student accidents during school or during athletic programs. If your child is hurt during school or while participating in an athletic program, your child must report the injury immediately and be seen by the school nurse or the athletic trainer. At that time, an accident report will be filled out by either the school nurse or the athletic trainer.

The District does have in place a secondary insurance policy, with the student's private insurance being primary. The student accident insurance coverage will be at 80% of eligible claims with a maximum out-of-pocket not to exceed $2,500.00 per accident. The student accident insurance requires you to comply with all of the requirements of your private insurance and is not intended to cover **all** bills related to an accident. In the event of an accident, it is recommended that you contact the insurance company directly to discuss the coverage afforded to your specific accident and any assistance you may need with filling out the claim form. They can be reached at Bob McCloskey Insurance (BMI), 1-800-445-3126.

If you choose to file a claim, you need to request a student accident claim form from the school nurse or the athletic office. The school nurse or the athletic trainer will fill out the first section of the claim form and give the claim form to the parent/guardian to submit to the insurance company. **The claim form must be submitted to the insurance company within 90 days of the date of the accident or coverage will be denied.** Please note that the student accident policy is written on an excess basis, which means that all claims must be submitted to the parent/guardian's health insurance first. If the student is not covered by the parent/guardian's health plan or the parent/guardian does not have health insurance, then a letter from the parent/guardian's employer must be submitted along with the claim form stating such.

Sincerely,

Steven W. Corso, CPA
School Business Administrator/Board Secretary

SWC:lt

STUDENT ACCIDENT REPORTING

1. When a student is injured, an accident report should be filled out along with a student accident claim form.

2. The first section of the student accident claim form must be filled out by either the nurse or a school official and **then must be given to the parent/guardian to fill out and send in**. The parent/guardian should read directions on back of claim form.

3. Once the accident report and student accident claim form (first section only) are complete, a copy of each should be sent to the Board Office.

4. The completed claim form should be mailed by the parent/guardian within 90 days of the date of the accident to:

   BMI Benefits
   PO Box 511
   Matawan, NJ 07747

5. The parent/guardian must immediately submit a claim for all medical expenses to the company that administers their personal or group insurance, as there are time limitations.

   * Please note that the student accident policy is written on an excess basis. This means that all claims must be submitted to the parent/guardian's health insurance first. If the student is not covered by the parent/guardian's health plan or the parent/guardian does not have health insurance, then a letter from the parent/guardian's employer must be submitted along with the claim form stating such.

6. If any further information is needed, call BMI at 800-445-3126 or GR Murray at 609-924-5000. **DO NOT CALL THE SCHOOL OR BOARD OFFICE.**

As always, coverage is determined solely by the Insurance Company.

Student/Athletic Accident Insurance

The Board of Education has purchased insurance coverage to protect all students against accidental injury during all school sponsored and supervised activities, whether at the school or away, including participation in interscholastic athletics. This coverage is provided by Markel Insurance Company.

This insurance plan is **Excess** coverage, i.e. you must submit all bills to your own insurance carrier first. The school policy will pick up the unpaid balances, up to the limits of the policy.

Although this coverage is very broad, there are restrictions, limitations, and exclusions in this policy. In some situations, medical bills may not be covered in full. Parents should understand that medical expenses are their own responsibility, not the schools. Some of the important benefits and limitations of the plan are:

1. Maximum Medical Benefit is $1,000,000.
2. Treatment must commence within 90 days of the date of injury, or there is no coverage.
3. Physical Therapy Treatment (including Chiropractic) has a limit of $10,000. (A letter of Medical Necessity is required).
4. Benefits are payable for up to 3 years from the date of injury.

All injuries should be immediately reported to a coach, nurse or faculty advisor. Claim forms will be provided by the school, but it is the parents' responsibility to:

1. Submit the claim form with Part 2 filled out completely (any omissions will delay the processing of the claim).
2. Submit all itemized bills (monthly statements will not do).
3. Submit the statement (EOB-Explanation Of Benefits) received from your own insurance Carrier showing amounts paid and balances due, or, a letter of denial stating the claim is not covered. One of these letters is required for any payments to be made.

If you have no other medical insurance, you will receive a letter from your insurance carrier requesting employer information. Fill this out and return it to the carrier immediately and the claim will be processed. Failure to return this letter will result in a delay or denial of the claim.

It is your responsibility, and to your benefit, to submit the necessary papers as soon as possible, as the claim cannot be paid until all papers are submitted. Only one claim form per accident is required.

All claim forms, bills, and the letters from other insurance carriers are to be forwarded to, and questions regarding the coverage answered by Bob McCloskey Insurance, P.O. Box 511, Matawan, NJ 07747, 1-800-445-3126.

STUDENT ACCIDENT CLAIM FORM

HOW TO FILE YOUR CLAIM

1. Complete this form within 90 days.
2. Attach itemized bills.
3. Mail to: BMI Benefits
   P. O. Box 511
   Matawan, NJ 07747
   Phone Number: 1-800-445-3126

MARKEL INSURANCE COMPANY

FLORIDA REQUIRED STATEMENT - Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing false, incomplete or misleading information is guilty of a felony of the third degree.

PART 1: SCHOOL

School or District Name: _____ Policy No.: _____

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

Claimant's Name: _____ Date of Birth: _____ ☐ Male or ☐ Female
MM DD YY

Date of Injury: _____ Time: _____ ☐ AM ☐ PM Grade: _____
MM DD YY

Where did injury occur? _____

How did injury occur? _____

Nature of Injury: _____

If athletics, please name the sport: _____ What type: ☐ Intramural ☐ Interscholastic ☐ Other: _____

On date of injury, what time did school start for this student? _____ What time was student dismissed from school? _____

At the time of injury, was the claimant involved in any activity under the jurisdiction of the Policyholder? ☐ Yes ☐ No

Under whose supervision? _____ Was he/she a witness? _____

Signature: x _____ Title _____ Date _____

(Must be signed by a school official if the accident was school related)

PART 2: Claimant's Section
Provide both *claimant* and *parent* information

Claimant Information

Claimant's Social Security Number _____ Phone Number (___) _____

Claimant's Street Address _____ City _____ State _____ Zip _____

Parent Information

Claimant's Father's Name _____ Social Security Number _____

Father's Employer _____

Street Address _____ City _____ State _____ Zip _____

Claimant's Mother's Name _____ Social Security Number _____

Mother's Employer _____

Street Address _____ City _____ State _____ Zip _____

Please list ALL OTHER insurance policies:

Name of Other Insurer: _____ ☐ No Other Insurance

Address: _____ ☐ Group _____ Policy No. _____

Phone # _____ ☐ Individual _____ Policy No. _____

Name of Other Insurer: _____ ☐ Other _____ Policy No. _____

Address: _____

Phone # _____

AUTHORIZATION FOR RELEASE OF INFORMATION: I AUTHORIZE any physician, medical care provider, hospital, clinic, medical care facility, insurance company, government-sponsored health plan, or employer having information available as to diagnosis, treatment and prognosis with respect to any illness, injury, physical or mental condition, and/or treatment for me or my minor children now or in the past, to give to Markel Insurance Company (MIC) or its legal representative, any and all such information.
I UNDERSTAND the information obtained by the use of the Authorization will be used by MIC to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by MIC to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize.
KNOW that I may request to receive a copy of this Authorization.
AGREE that a photographic copy of this Authorization shall be as valid as the original. I also AGREE this Authorization shall be valid for a period of two years from the date shown below. I may revoke this authorization at any time by written request to MIC.
CERTIFY that the information given by me in support of this claim is true and correct

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

AFFIDAVIT: I verify that the statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim, I will reimburse Markel Insurance Company to the extent for which Markel Insurance Company would not have been liable.

Claimant, Parent or Authorized Representative's Signature: _____ Date _____
If Authorized Representative, Relationship to Patient or Legal Designation: _____

ITEMIZED BILLS FOR MEDICAL EXPENSES MUST BE ATTACHED

IF DENTISTRY, ANSWER ALL QUESTIONS BELOW, IN ADDITION TO THOSE ABOVE.

1. State exactly which teeth were involved in the accident and indicate them on the chart:

   _____

   _____

2. Describe exact nature of injury:

   _____

   _____

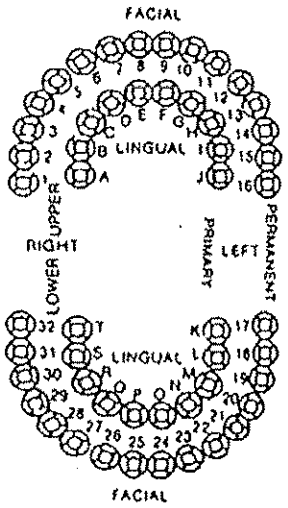
3. Describe condition of injured teeth prior to accident:
   ☐ Whole, sound and natural ☐ Filled ☐ Capped ☐ Artificial
4. Comments:

   _____

   _____

   _____

   _____



SIGNED: _____ DEGREE: _____ DATE: _____
PRINT NAME: _____
I.D. OR S.S. NO. _____ (THIS MUST BE INCLUDED) PHONE NO. (____)_____

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

IMPORTANT: This form must be completed and returned WITHIN 90 DAYS from the date of treatment, accompanied by all bills incurred to that date.