TO: **School District Administration**

SUBJECT: Student Accident Insurance for the upcoming school year

Enclosed are the supplies for the Student Accident Insurance Program selected by your School District. **Please provide the enclosed information to the school employee(s) assigned to complete a claim form.**

The documents enclosed include the following:

1. A small supply of **Claim Forms**. **If an athletic accident report form is completed and the injury requires medical attention by a licensed physician, then a student athletic accident claim form should be completed as well.** A school employee must complete Part A of the form for each injury, and give it to the student's parent/guardian to complete Part B. The policy provides coverage for accidents occurring during an exclusively sponsored and school employee supervised activity. "How to file a claim" is available on the reverse side of the claim form. Additional fillable claim forms are available on our website (www.sas-mn.com) under K-12 Students & Parents – Find my School.

2. A small supply of **Summary of Coverage**. This summary explains the specific medical benefits of the plan selected by the school district. We suggest that when a claim form is given to a family, a copy of the summary of coverage should be given as well. Additional summary of coverage forms are available on our website (www.sas-mn.com) under K-12 Students & Parents – Find my School.

3. The primary contact associated with your school district's student accident plan will be given an administrative access code for our website (www.sas-mn.com). This access code should be entered after selecting K-12, Administrators, and entering in the correct code under School Login. Once accessed, he/she will be able to review the master policy, roster of insured students (for extended coverage) and claim status information. For the privacy of the families involved, this information should not be shared with the general public.

Reminder: A claim should be submitted when a student sustains an accidental bodily injury that requires treatment from a licensed physician. First treatment must be received from a licensed physician within 60 days from the date of injury.

The cooperation in administering the student accident program is appreciated.
If you have any questions, please contact us at (800) 328-2739.

P.O. Box 196 Stillwater, MN 55082-0196 Toll Free: (800) 328-2739 – Fax: (651) 439-0200

Student Accident Insurance

Policy Identification Form and Claim Procedures

Claims Administrator:
Student Assurance Services, Inc. (SAS)
P.O. Box 196
Stillwater, MN 55082
(800) 328-2739
Monday-Friday 8:00am to 4:30pm CST

Website: www.sas-mn.com
1) Under K-12 Students/Parents select "Find My School"
2) Select State where the school is located
3) Search and select school name
Provides:
Plan Summary of Benefits
Claim Form

Policyholder Name: **Sunflower County Consolidated School District**

Policy School Year: **2023-2024**

Policy Number: **23-26-4575-480-129-3**

NOTICE TO PARENTS/STUDENTS AND PROVIDERS: Using this Policy ID form is NOT a guarantee of benefits or confirmation of coverage under the plan. Benefits and eligibility will be evaluated when an accident claim is submitted for payment.

A completed SAS claim form must be submitted prior to or along with itemized bills. Only one claim form for each accident needs to be submitted.

Use either the student's social security number or date of birth as a personal member ID.

Parents or providers must first submit copies of itemized bills to the student's other medical and dental insurance plan. This plan pays second or after other insurance coverage. (Coverage is primary in ID, and primary if parent-paid in IL) Also, this plan does not cover penalties imposed by the student's other insurance coverage for failure to use a preferred provider. (In KS penalty does not apply)

Submitting the accident claim and related expenses are parents/student's responsibility. DO NOT rely on the provider or school to send information.

To File an Accident Claim

a) Download and print a claim form on the website **www.sas-mn.com** under school look-up.
b) Notify the school immediately if the injury is school related, a school official must complete Part A of the claim form.
c) Parents must complete Part B of the claim form. Answer all questions. If this injury is NOT school-related, then you may complete both Part A and Part B of the claim form.
d) Parents or providers must submit itemized bills (often called UB04 or CMS 1500) that contain date of service, procedure code, diagnosis code, federal tax ID number, and NPI number of the hospital or doctor. Balance due statements cannot be processed.
Note: You can leave a COPY of the claim form and this form with the provider or facility. Providers may submit itemized bills directly to SAS on the student's behalf. However, some providers may require payment at the time service is provided or may send the bill directly to the parent.
e) Parents or providers must submit explanation of benefits (EOBs) from the student's primary insurance coverage showing write-offs, copays, coinsurance, deductibles, and payments. This plan pays second to other dental or health insurance coverage. (Coverage is primary in ID, and primary if parent-paid in IL)
f) Mail the completed claim form, itemized bills, and other insurance EOBs to:

Student Assurance Services, Inc.
P.O. Box 196
Stillwater, MN 55082

Please allow 30 days after submitting the accident claim before calling to check claim status at (800)328-2739. The SAS claims office is available for calls between 8:00 a.m. to 4:30 p.m. Central Standard Time, Monday - Friday. Providers that receive electronic payments through Instamed must status claims with them.

There is a timely filing deadline of one year and ninety days to submit proof of loss. Do not wait to send information as this may result in claim denial. (Timely filing is one year and 180 days in North Carolina and does not apply in Utah)

PROOF OF CLAIM

There is a timely filing period of one year and ninety days. Do not wait to send information as this may result in claim denial.

Email, Fax or Mail completed form to:
STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MINNESOTA 55082

NOTICE: Anyone who knowingly misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment.

CLAIM PROCEDURE:

1. A school official must complete and sign PART A*.
2. The student's parent or guardian must complete PART B.
3. See Page 2 for important claim procedures.

TO BE COMPLETED BY A SCHOOL OFFICIAL

PART A: NOTICE OF INJURY

1. Name of School ______ School District Name ______
   School Address ______ (City) (State) (Zip)
2. Name of Student ______ Grade ______
3. Date of Injury ______ ☐ AM ☐ PM
4. Under whose supervision? ______ Was he/she a witness? ______
5. The accident was incurred while the Insured was participating in:

INTERSCHOLASTIC SPORTS

☐ Practice
☐ Game
☐ Travel to/from Sport
What Sport? ______

NON-INTERSCHOLASTIC SPORTS

☐ Travel to/from School
☐ In classroom
☐ Other - Activity ______
☐ On school grounds
☐ Non-school activity
☐ Physical Education

6. Part of the body injured ______ ☐ Left ☐ Right
7. Describe in detail how and where the injury occurred ______

Reported by ______
(Signature of School Official) (Title) Date(mm/dd/yyyy)

(*Part A may be completed by the parent if Full-Time Coverage was purchased.)
IMPORTANT INFORMATION ON Page 2

TO BE COMPLETED BY A PARENT OR GUARDIAN

PART B: PARENT STATEMENT

1. Students Name ______ Date of Birth ______ Date (mm/dd/yyyy)
   Students Social Security # ______ - ______ - ______
   Parents Name ______ Relationship to Insured ______
   Mailing Address ______
   (Street, Route, Box, Apt., or Lot #) (City) (State) (Zip)
2. Home phone number ______
3. Father's Occupation ______ Employer ______
   Mother's Occupation ______ Employer ______
4. Do you have insurance coverage? ☐ Yes ☐ No Is the student covered under your insurance plan? ☐ Yes ☐ No
   Name of Insurance Company ______
   ☐ Group ☐ Individual ☐ Medicaid ☐ CHIP ☐ Tricare ☐ None

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of the claimant's physical or mental health, to give the information to STUDENT ASSURANCE SERVICES, INC. To facilitate rapid submission of such information, I authorize all said sources, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. A photocopy of this authorization shall be as valid as the original. This authorization expires one year from the date signed. By entering my name below, I am indicating my intent to sign this claim form and warrant that all of the information provided is true, complete, and accurate.

______ Date (mm/dd/yyyy) ______ (Print Name of Student/Patient) ______ (Signature of Parent or Guardian)

... TO FOLLOW WHEN FILING A CLAIM:

1. Only one Student Assurance Services, Inc. (SAS) completed claim form for each accident needs to be submitted. Students must be treated by licensed physician or facility within the required time as stated in the policy.
2. The claim form and benefit summary are available at SAS website: **www.sas-mn.com**. However, using this form is not a guarantee of benefits or confirmation of coverage under the plan. Benefits and eligibility will be evaluated when the claim is submitted, subject to all applicable terms, conditions, limitations and exclusions of the plan.
3. A school official **must** complete Part A of the claim form for all school related accidents. The parent or guardian must complete Part B – Parent Statement of the claim form. Answer all questions on the claim form. If the accident is not school related, the parent or guardian **may** complete both Part A and Part B.
4. Submit copies of the student's **itemized bills** with the completed claim form. **Balance due statements cannot be processed.** These itemized bills often called UB-04 or CMS-1500 provide the Address, Date of Service, Procedure Code, Diagnosis Code, Federal Tax ID Number and NPI number of the treating physician or facility. **This plan has a timely filing deadline, do not wait to send information.**

   Note: A copy of the claim form can be given to the treating physician or facility. The provider may submit UB-04 or CMS-1500 itemized bills directly to SAS on the student's behalf. However, do NOT depend on the provider to submit the claim form or itemized bills to SAS. It is the parent/guardian's responsibility to provide this information.
5. **Submit copies of the itemized bills to the student's primary family and/or group insurance company first**, even if the other insurance plan has a large deductible or copay. This plan pays second or is supplemental to all other valid coverage (does not apply to SAS primary plans). This plan does not cover penalties imposed for failure to use providers preferred or designated by the other primary insurance plan. The other insurance plan will provide an Explanation of Benefits (EOB) showing payment, write-off, deductible, copay, and coinsurance.
6. Mail, fax, or email the completed claim form, student's itemized bills and other insurance EOBs to:

STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MN 55082-0196
Fax: (651) 439-0200
Email: claims@sas-mn.com
Phone Number: 1-800-328-2739

NO CLAIM CAN BE PROCESSED UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN PROVIDED TO SAS:

1. **Completed Claim Form**
2. **Itemized Bills (UB-04 or CMS-1500)**
3. **Explanation of Benefits (EOB) from the primary insurance plan**
4. **FOR DENTAL CLAIMS - American Dental Association Standardized itemized billing form**

PLEASE REFER TO THE MASTER POLICY ISSUED TO THE SCHOOL/SCHOOL DISTRICT FOR SPECIFIC DETAILS.

Student Accident Insurance

Policy GA-2200Ed.11-16(ID)(LA)(MN)(NC)(ND)(OH)(SD)(UT)

SUMMARY OF COVERAGE

The school purchased a group insurance policy that provides benefits for accidental bodily injury incurred while the student is:

a. Practicing for or competing in interscholastic sports and participating in group extracurricular activities which are exclusively sponsored and supervised by the School, as a representative of the policyholder and under the direct and immediate supervision of an employee of the policyholder.

b. Traveling directly to or from such practice, participation, or competition in a vehicle designated by the policyholder and under the supervision of an employee of the policyholder.

The Medical Benefits and Exclusions below apply to the summary of coverage above.

MEDICAL BENEFITS

When injury covered by this policy results in treatment by a licensed physician within 60 days from the date of injury, the Company will pay the Usual and Customary (U&C) expenses incurred for covered services as listed below, for expenses actually incurred within one year from the date of injury up to maximum medical benefit of **$50,000 per injury**. Unless stated otherwise, all amounts below are per injury.

This insurance plan is secondary to all other valid coverage. A claim must be filed with other valid coverage first! (This coverage is primary in ID) This insurance plan does not cover penalties imposed for failure to use providers preferred or designated by the primary coverage. (In NC, other valid coverage does not include automobile or third-party liability coverage)

PHYSICIAN'S SERVICES

a) **Surgical Care** (surgeon, assistant surgeon, anesthesia) - U&C, up to $5,000
b) **Nonsurgical Care** (includes physiotherapy; 1 visit per day) - U&C, up to $100 per visit, maximum 20 visits

HOSPITAL CARE

a) **Inpatient Care**
  1) Hospital Semi-private Room - the usual daily charge up to $700 per day
  2) Hospital Miscellaneous Services (includes charges for registered nurse) - U&C, up to $1,000

b) **Outpatient Care** (includes facility charges for day surgery and emergency room) - U&C, up to $2,000

NOTE: Benefits for Hospital miscellaneous and outpatient care charges are limited to services not scheduled under Medical Benefits.

RADIOLOGY SERVICES (includes x-ray, MRI, CT scan, bone scan, and charges for reading) - U&C, up to $1,000

DENTAL TREATMENT (in lieu of all other medical benefits; for repair and/or replacement of sound and natural teeth) (In SD, sound and natural is deleted) - U&C, up to $800

AMBULANCE SERVICES - U&C, up to $800

ORTHOPEDIC APPLIANCES (when prescribed by a physician for healing; includes charges for durable medical equipment) - U&C, up to $1,000

PRESCRIPTION DRUGS (take home) - U&C, up to $500

REPLACEMENT EYEGLASSES, HEARING AIDS AND CONTACT LENSES (when medical treatment is required for a covered injury) - U&C, up to $1,000

LABORATORY SERVICES (Outpatient) - U&C, up to $500

SHOTS AND INJECTIONS (Outpatient, in lieu of physician non-surgical care) - U&C, up to $300

MOTOR VEHICLE INJURY - Same as any Injury, up to $5,000

The policy contains a provision limiting coverage to usual and customary charges. This limitation may result in additional out-of-pocket expenses for the insured.

EXCLUSIONS - No Benefits Will Be Allowed For:

1. Any sickness, disease, infection (unless caused by an open cut or wound), including but not limited to: aggravation of a congenital condition, blisters, headaches, hernia of any kind, mental or physical infirmity, Osgood-Schlatter disease, osteochondritis, osteochondritis dissecans, osteomyelitis, spondylolysis, slipped femoral capital epiphysis, orthodontics.
2. Injuries for which benefits are payable under Workers' Compensation or Employer's Liability Laws. (In NC, benefits are excluded if the employer, employee or carrier is responsible or liable according to final adjudication or settlement order under state law)
3. Any Injury involving a two or three-wheeled motor vehicle or snowmobile or any motorized or engine driven vehicle not designed primarily for use on public streets and highways, unless the insured is participating in an activity sponsored by the Policyholder. (In ID, an insured person must be participating as a professional)
5. In Ohio - Reinjury if the insured participated in a covered activity against medical advice.

It is not the intent of this policy to provide benefits for an existing medical problem. A re-injury will be covered if the insured has been treatment free for a period of 180 days prior to the effective date of the policy. (In OH, this provision does not apply)

ACCIDENTAL DEATH AND DISMEMBERMENT

When injury covered by this policy results in Accidental Death or Dismemberment within 180 days from the date of accident, the following benefits will be payable.

Loss of Life	$5,000	Double Dismemberment	$10,000
Loss of an Eye	$5,000	Single Dismemberment	$ 5,000

CLAIM PROCEDURE

Filing of the claim is the parent's responsibility.

1. Parents notify the school and obtain a claim form immediately. The school completes Part A of the claim form if it is a school injury.
2. Parents complete Part B of the claim form. Answer all questions.
3. Parents submit copies of the student's itemized bills to the student's family medical or dental coverage first, even if there is a large deductible. The other insurance plan will send a report called an Explanation of Benefits (EOB). (This coverage is primary in ID)
4. Parents send the completed claim form, copies of the student's itemized bills and the EOB to:
   STUDENT ASSURANCE SERVICES, INC.
   PO BOX 196 • STILLWATER MN 55082
5. The claim will be completed when all of the above documents have been provided. For claim questions, contact Student Assurance Services, Inc. at 1-800-328-2739, between 8am-4:30pm CST.

NOTE: Student must have been treated by a licensed physician within **60 days** of the date of injury. Proof of claim must be submitted within 90 days from the date of accident, or a reasonable time thereafter not to exceed one year. Itemized bills should be submitted within 90 days from the date of treatment or a reasonable time thereafter not to exceed one year. The company is responsible only for expenses incurred within one year from the date of injury. (In NC, itemzied bills must be received within 180 days from the date of treatment, not to exceed one year) (In UT, one year filing limit does not apply unless Company can show it was prejudiced)

EFFECTIVE AND EXPIRATION DATE

Coverage becomes effective the first day of authorized interscholastic sports practice or extracurricular activity. Coverage will expire on the last day of the authorized season of the current school year.

This provides a very brief description of some of the important features of the insurance policy. It is not the insurance policy and does not represent it. A full explanation of benefits, exceptions and limitations is contained in the Group Accident Insurance Policy Form GA-2200Ed.11-16 (and any state specific) and any applicable endorsements. This policy is considered term accident insurance (except in ID) and is non-renewable. This product may not be available in all states and is subject to individual state regulations. The Master Policy is issued to the School District/School. A copy of the Privacy Notice and Certificate of Coverage (where applicable) may be obtained on the website www.sas-mn.com.

Underwritten by

Ameritas Life Insurance Corp.
Lincoln, Nebraska

Administered by
STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MINNESOTA 55082

Return Address ______________________

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PLACE STAMP
HERE
POST OFFICE
WILL NOT DELIVER
WITHOUT
POSTAGE

STUDENT ASSURANCE SERVICES, INC.
P O BOX 196
STILLWATER MN 55082-0196