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SCHOOL INSTRUCTIONS
FILING A CLAIM
2015-2016 PROCEDURES AND INFORMATION MEMO

Team Assure
A Division of Planned Benefit Services

Schools participating in the Accident Group Medical Zero Deductible GAP Plan

UPON ACCIDENTAL INJURY:

A school representative (coach or principal) should obtain the Notification of Injury Form from your School. Only one form per injury is needed. To be a covered accident, injury must occur during an association/school sponsored and supervised activity, treatment must commence within 30 days of injury by a legally qualified medical doctor, and injury form must be submitted within 90 days of the injury. There is a one year benefit period.

1. Please throw away all older forms and copies. Use the new Notification of Injury Form and this procedure memo to make copies.

2. Read the claim instructions on top of the Notification of Injury Form.

3. Part I - Notification of Injury Form - Answer each question completely.
   To protect the school, have the parent or guardian sign and date line 14.

4. Part II - Notification of Injury Form - Have the parent complete lines 1 through 8

5. Keep a copy for your records.

6. Give a copy of the Parent Instructions sheet to the parent/guardian.

7. Inform the parent to send a COPY of the injury form immediately to the following address:

   ABT Plan Administrator
   P.O. Box 382048
   Birmingham, AL 35238-2048

8. Inform the parent to send copies of itemized provider bills and corresponding explanation of benefits (EOB'S) from the other insurance plans as they arrive. Parent/guardian must understand that this is a secondary plan with a one(1) year benefit period and that they should first file on and follow procedures of any other individual or family medical plans(Private, All-Kids, Champus, Medicare, or Medicaid, etc.). It is the parent/ guardian's responsibility, not medical providers or school, to submit their form completed properly.

HELP DESK INSTRUCTIONS
PARENTS/SCHOOL OFFICIALS
IF, AFTER SUBMITTING A CLAIM BY MAIL OR FAX YOU NEED TO ASK FOLLOW UP QUESTIONS
Please submit any requests for follow-up information
By email to: Support@Kennion.com or by visiting: http://support.Kennion.com
Our helpdesk page has a unique SSL Certificate and all information transferred is encrypted with 128bit security. In addition, the system is scanned on a regular basis using PCI Security Scanning from Trust Guard.

PARENT/GUARDIAN INSTRUCTIONS
FILING A CLAIM
2015-2016 PROCEDURES AND INFORMATION MEMO

1. Read the claim instructions on top of the Notification of Injury Form.
2. PART I - Sign and date line 14 (parent/guardian acknowledgement of receipt)
3. PART II – Complete lines 1 through 8 of the Notification of Injury Form
4. Send a COPY of the injury form, COPIES of bills, and COPY of explanation of benefits (EOB'S) from the other insurance plans to the following address:

   ABT Plan Administrator
   P.O. Box 382048
   Birmingham, AL 35238-2048

   DO NOT DELAY. Send in Notification of Injury Form as soon as injury occurs.

5. For answers to questions about the status of your claim call:

   1-888-283-3515
   Monday – Friday
   8:00 am - 5:00 pm CST

6. File on and follow procedures of any other individual or family medical plans (Private, All-Kids, Champus, Medicare, or Medicaid, etc.). This is a secondary accident medical plan with a one (1) year benefit period.
7. Send COPIES of bills and explanation of benefits (EOB'S) from the other insurance plans as they arrive. **It is the parent/guardian's responsibility, NOT medical providers or school to submit their form completed properly.**

IMPORTANT: Keep the original for your records.
The parent, not a provider, must submit: the Injury Form, EOB's, and provider balance bills to the above address.

HELP DESK INSTRUCTIONS
PARENTS/SCHOOL OFFICIALS
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GAP PLAN
2015-2016 School Year

MAIL FORM TO:
ABT Plan Administrator
P.O. Box 382048
Birmingham, AL 35238-2048
1-888-283-3515

NOTIFICATION OF INJURY FORM

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

FOR CLAIMS ADMINISTRATIVE USE ONLY

Policy Number
Reference Number
Coverage Code

- FULL EXCESS – Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance. You must submit your claim to all other insurance companies first. When you receive their Benefit Statement (EOB-explanation of benefits), send it to us, along with corresponding itemized bills. Benefits for eligible expenses will be paid per Benefit Plan terms.
- The claim form must be submitted within 90 days from the date of injury. Treatment must commence within 30 days from the date of injury by licensed medical doctor. Each injury has a one year benefit period.
- Note the name of the school district and Athletic Association on all bills and correspondence.

NO ADDITIONAL CLAIM FORM IS NECESSARY.

- Do not rely on the provider to file your claim for you. You are responsible for filing your claim form and all additional information.

PART I – SCHOOL REPORT

1. Name of School			2. School District and Athletic Association			
3. Name of Student - Last	First	Middle Initial	4. Social Security No.	5. Grade	6. Birthdate	7. Sex

8. Nature of injury (please describe fully, indicating what part of body was injured – e.g., broken arm, sprained ankle. etc.

9. Describe how accident occurred. (Give all possible details.) MUST BE A BODILY INJURY DUE TO ACCIDENT.

10. Did Accident Occur:	Yes	No	11. a) Date of Accident	12. a) Name of Activity
a) While claimant was supervised	☐	☐		
b) During sponsored activity	☐	☐		
c) During programmed hours	☐	☐	b) Time	13. a) Name & Title of Supervisor
d) On activity premises	☐	☐		
e) While traveling directly and uninterruptedly to or from home premises and school for regular school sessions or school sponsored and supervised activities	☐	☐	c) Place	14. Parent/Guardian acknowledgement of receipt Date: Initials:
15. Signature of School Representative			16. Title	17. Date

NO CLAIM WILL BE PROCESSED UNLESS ALL INSTRUCTIONS ARE FOLLOWED AND FORM IS COMPLETE IN FULL

PART II – TO BE COMPLETED BY CLAIMANT – OR BY PARENT IF CLAIMANT IS A MINOR

1. Name of Father or Guardian	2. Social Security Number
3. Name of Mother or Guardian	4. Social Security Number
5. Address of Parents or Guardian/or Claimant	5A. Telephone Number

6A Father or Guardian's Insurance Company(ies)	6B. Mother or Guardian's Insurance Company(ies)	Check One:	☐ Individual ☐ Group
7A. Name, Address & Phone Number of Father or Guardian's Employer	7B. Name, Address & Phone Number of Mother or Guardian's Employer		

8. List other insurance policies under which claimant is insured	Policy No.		
1.	1A.		☐ Individual ☐ Group
2.	2A.		☐ Individual ☐ Group

Affidavit: I verify that the above statement on other insurance is accurate and complete. I understand that I am required under Federal Law to purchase and maintain in force a Major Medical Health Plan that is compliant with the Affordable Care Act (ACA).

Signature of Parent or Guardian: _____ Date: _____

Authorization: I hereby authorize any physician or hospital that has treated or attended the above claimant to furnish the insurance company or its representatives any information requested. A photocopy of this authorization is to be considered valid.

_____ _____

Signature of Insured (Parent or Guardian if Insured is under 18) Date