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 ☐ Travel to/from Sport
☐ Game
What Sport? _____

NON-INTERSCHOLASTIC SPORTS

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

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, or Box) (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 ☐ 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 PARENT OR GUARDIAN:

STEPS 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 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

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

Broad Group - $10,000 Per Injury Plan
Policy Form GA-2200(KS)Ed.11-16

SUMMARY OF COVERAGE

The Kansas City Archdiocese CYO purchased a group insurance policy that provides benefits for accidental bodily injury incurred while the student is:

Participating in a Kansas City Archdiocese CYO activity which is sponsored and supervised by the policyholder and is under the direct supervision of the policyholder or an employee of the policyholder. Includes traveling directly to and from such activity in a vehicle provided by the policyholder and under the direct supervision of the policyholder or 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 and supplies as listed below, for expenses actually incurred within one year from the date of injury up to the specified maximum medical benefit of **$10,000 per injury.** Unless stated otherwise all amounts listed below are per injury.

The Company's liability for benefits payable on account of expense incurred, for any hospitalization, medical, surgical, and other services resulting from covered Injury of the covered person, shall be limited to that part of the expense, if any, which is in excess of the total benefits payable for the same loss, on a provision of service basis or on an expense incurred basis under any medical or service contract, self-funded plan, automobile medical payment coverage, or any plan under federal, state or local law (except Medicaid). If one or more of the other policies, plans or service contracts provides benefits on an excess insurance or an excess coverage basis, benefits should be paid first by the company or service plan whose policy or service contract has been in effect for the longer period of time at the date of such loss.

PHYSICIAN'S SERVICES

a) **Surgical Care** (surgeon, assistant surgeon, anesthesia) - U&C, up to $3,500
b) **Nonsurgical Care** (does not include physiotherapy) - U&C, up to $60 per visit, maximum 10 visits

PHYSIOTHERAPY - (for any form of therapeutic or manual treatment provided by a physician, including but not limited to: physical or mechanical therapy, diathermy, ultrasonic, whirlpool or heat treatments, EMS, or manipulation; includes office visit) - U&C, up to $60 per visit, maximum 5 visits

HOSPITAL CARE

a) **Inpatient Care**
   - Hospital Semi-private Room - U&C, up to $500 per day
   - Hospital Miscellaneous Services (includes charges for registered nurse)- U&C, up to $5,000

b) **Outpatient Care** (includes facility charges for day surgery and emergency room) - 80% U&C, up to $3,500

NOTE: Benefits for hospital miscellaneous and outpatient care charges are limited to services not scheduled elsewhere under medical benefits.

RADIOLOGY SERVICES (includes x-ray, MRI, CT scan, bone scan, and charges for reading) **-** U&C, up to $750

DENTAL TREATMENT (in lieu of all other medical benefits; for repair and/or replacement of each sound and natural tooth) - U&C, up to $300 per tooth

AMBULANCE SERVICES - U&C, up to $500

ORTHOPEDIC APPLIANCES (when prescribed by a physician for healing; includes charges for durable medical equipment) - U&C, up to $300

PRESCRIPTION DRUGS (take home) - U&C, up to $300

REPLACEMENT EYEGLASSES, CONTACT LENSES, AND HEARING AIDS (when medical treatment is required for a covered injury) - U&C, up to $300

LABORATORY SERVICES (Outpatient) - U&C, up to $300

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

MOTOR VEHICLE INJURY - Same as any injury

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.
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.
4. No benefits are payable for accidental bodily Injuries arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any automobile policy.

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.

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	$ 2,500	Double Dismemberment	$10,000
Single Dismemberment	$ 2,500		

CLAIM PROCEDURE

Filing of the claim is the parent's responsibility.

1. Parents should notify the CYO administrator and obtain a claim form immediately. The administrator completes Part A of the claim form if it is a CYO injury.
2. Parents complete Part B of the claim form. Answer all questions.
3. Parents submit copies of student's itemized bills to 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).
4. Parents send the 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 (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.

EFFECTIVE AND EXPIRATION DATE

Coverage becomes effective the first day of authorized CYO activities. Coverage will expire on the last day of the authorized CYO activities 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 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 may be obtained on the website www.sas-mn.com

Underwritten by

Ameritas

Ameritas Life Insurance Corp.
Lincoln, Nebraska

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

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: **Kansas City Archdiocese (KC-CYO)**

Policy School Year: **2024-2025**

Policy Number: **15-26-6664-201-472-4**

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)