August 2015

Dear Parent/Guardian,

School sports participation, like much of what our children enjoy, has some inherent risk of injury. However, the leadership of interscholastic athletics in this school district and across the state of Michigan is attempting both to provide as safe an experience as possible and enhance the health of our student-athletes.

As a part of these efforts, the Michigan High School Athletic Association provides all of its member schools with a Catastrophic Accident Medical Insurance Policy which pays up to $500,000 for medical expenses left unpaid by other insurance after a deductible of $25,000 per claim in paid medical expenses has been met. All students enrolled in grades 7 through 12 at MHSAA member schools who are eligible under MHSAA rules and participating in practices or competition in sports under the MHSAA's jurisdiction are covered by this policy for injuries related to their athletic participation.

Beginning with the 2015-16 school year, the Michigan High School Athletic Association is also providing eligible athletic participants at each MHSAA member junior high/middle school and high school with additional insurance that is intended to pay accident medical expense benefits resulting from a suspected concussion. The injury must be sustained while the athlete is participating in an MHSAA covered activity. Policy limit is $25,000 for each accident. Covered students, sports and situations are identical to the catastrophic accident medical insurance which, if the $25,000 threshold is reached, would require a separate claim to be made.

This new program intends to assure that all eligible student-athletes in MHSAA member schools in grades 7 through 12, male and female, in all levels of all sports under the jurisdiction of the MHSAA, receive prompt and professional attention for head injury events even if the child is uninsured or under-insured. Accident medical deductibles and co-pays left unpaid by other policies are reimbursed under this program to the limits of the policy.

Should you have need to make a claim under this new program, contact terri.bruner@kandkinsurance.com, or phone 800-237-2917 toll free.

Sincerely,

SUMMARY OF COVERAGE

Coverage Period: 7/01/2015 – 7/01/2016
Carrier: Nationwide Life Insurance Company
AM Best Rated A+ XV

Excess Accident Medical Limits:
Maximum: $ 25,000 per Injury
Usual & Customary 100%
Benefit Period: 1 Year
Deductible: $0 per claim
AD&SL: $5,000
AD&SL Aggregate $250,000

Eligible Persons:
All athletes participating in a Covered Activity.

Covered Activities:
Participating in practice or play of sports governed and/or sponsored by the Participating Organization.
Participating Organization: An organization which:
1. Elects to offer coverage under the Policy by completing a Participating Organization Application that has been accepted by Us (Nationwide);
2. Completes a participation agreement with the Policyholder; and
3. Remits the required Premium when due.

Definition of Injury:
For the Accident medical Expense benefits, the following definition of Injury applies:
A bodily injury which is:
1. Directly and independently caused by specific Accidental contact with another body or object;
2. a source of loss that is sustained while the Insured Person is covered under the Policy and while he or she is taking part in a Covered Activity.
3. Resulting in a concussion.

Definition of Concussion:
A specific brain injury defined as a complex pathophysiological process affecting the brain, induced by trauma to the brain, and diagnosed by a Physician practicing within the scope of his or her license.

How to File a Claim

To process your claim, please submit the following pieces of information:

1. Completed and Signed 'K&K Incident Report'
2. Complete and Signed 'Other Insurance Questionnaire'
3. Itemized Bills
4. Explanation of Benefits from your Primary Insurance Carrier

These documents should be mailed, emailed or faxed to:

K&K Insurance Group
Attn: Terri Bruner
1712 Magnavox Way
Fort Wayne, IN 46801

Terri.Bruner@kandkinsurance.com

(312) 381-9077 Fax
(800) 237-2917 Toll Free

The 'K&K Incident Report' enables the payer to open a claim for the treatment of your injury. To avoid delays in claim processing, please be sure to complete the 'Other Insurance Questionnaire'. The incident report must be signed by an MHSAA member school administrator.

Itemized Bills – please include copies of all medical bills, showing the name and address of the provider of service, date of service, type of service and the charges. Account Statements or 'Balance Due' statements are helpful, but do not contain all the information needed to process the claim.

Explanation of Benefits – If you have other medical insurance, all medical bills first be submitted to that carrier for its determination of eligibility and payment. If the charges are not paid in full by the other medical insurance carrier, we will need to see a copy of the 'Explanation of Benefits' prior to paying any benefits. If you do not have other insurance, the need for an 'Explanation of Benefits' will not apply to your claim.

d:r
DISSINGER REED

K&K INSURANCE
1712 Magnavox Way P.O. Box 2338
Fort Wayne, Indiana 46801
PH (800) 237-2917
Fax (312) 381-9077
http://www.kandkinsurance.com

K&K INCIDENT REPORT

Michigan High School Athletic Association Concussion Coverage

MHSAA michigan high school athletic association

(PLEASE PRINT)

NATURE
☐ BODILY INJURY ☐ OTHER:_____

TIME & PLACE OF INCIDENT
DATE:_____ TIME:_____ ☐ AM ☐ PM
EVENT NAME:_____
EVENT TYPE:_____ CONDUCTED BY:_____
LOCATION:_____

HAPPENED TO
NAME:_____ SSN:_____
DATE OF BIRTH: _____ SEX: ☐ Male ☐ Female PHONE: (____) _____
ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____

FUNCTION
AS: ☐ ATHLETE
☐ OTHER:_____

APPARENT INJURY OR DAMAGE
BODY PART:_____
CONDITION:_____
☐ ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER) OTHER:_____
☐ AMBULANCE, TAKEN TO:_____ CITY:_____
☐ FATALITY

OCCASION
WHAT WAS THE SITUATION AND EXACT LOCATION AT THE TIME OF THE INCIDENT?_____

INCIDENT DESCRIPTION
DESCRIBE WHAT HAPPENED:_____

WITNESSES (if known)
NAME:_____ NAME:_____
ADDRESS:_____ ADDRESS:_____
PHONE: (____) _____ PHONE: (____) _____

INSURED
NAME OF INSURED:_____ POLICY#:_____
CLUB NAME:_____ PHONE: (____) _____
CITY:_____ STATE:_____

INSURED REPRESENTATIVE
☐ MHSAA Member School Administrator ☐ OTHER:_____
NAME:_____ PHONE: (____) _____
TITLE:_____ ORGANIZATION:_____
SIGNATURE:_____ DATE:_____

COMPLETE ALL SECTIONS AND FAX OR MAIL IMMEDIATELY TO:

K&K INSURANCE GROUP, INC., P.O. BOX 2338, FORT WAYNE, IN 46801-2338

THIS FORM MUST INCLUDE THE INSURED NAME, POLICY NUMBER, AND SIGNATURE OF THE INSURED/REPRESENTATIVE BEFORE RETURNING OR PROCESSING MAY BE DELAYED

K&K INSURANCE

OTHER INSURANCE QUESTIONNAIRE

NAME OF CLAIMANT:_____ INTERNATIONAL STUDENT ☐ Yes ☐ No

EMANCIPATED STUDENT: ☐ Yes ☐ No

NAME OF INSURED:_____ POLICY NO:_____

FATHER

IS FATHER DECEASED? ☐ Yes ☐ No

IS FATHER LEGALLY RESPONSIBLE? ☐ Yes ☐ No

FATHER'S NAME (if injured is a minor)_____

SOCIAL SECURITY #:_____

EMPLOYED? ☐ Yes ☐ No SELF-EMPLOYED? ☐ Yes ☐ No

DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? ☐ Yes ☐ No

EMPLOYER NAME:_____

EMPLOYER ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE: (_____)_____

CONTACT PERSON:_____

Do you have group medical insurance coverage through your employment?

☐ Yes ☐ No

If no, please be advised K&K may contact your employer to verify no primary insurance is in force.

INSURANCE COMPANY:_____

INSURANCE COMPANY ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

POLICY NUMBER:_____

TYPE OF PLAN:
- ☐ HEALTH MAINTENANCE ORGANIZATION (HMO)
- ☐ PREFERRED PROVIDER ORGANIZATION (PPO)
- ☐ STANDARD MEDICAL AND HOSPITALIZATION COVERAGE
- ☐ OTHER (describe)_____

MOTHER

IS MOTHER DECEASED? ☐ Yes ☐ No

IS MOTHER LEGALLY RESPONSIBLE? ☐ Yes ☐ No

MOTHER'S NAME (if injured is a minor)_____

SOCIAL SECURITY #:_____

EMPLOYED? ☐ Yes ☐ No SELF-EMPLOYED? ☐ Yes ☐ No

DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? ☐ Yes ☐ No

EMPLOYER NAME:_____

EMPLOYER ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE: (_____)_____

CONTACT PERSON:_____

Do you have group medical insurance coverage through your employment?

☐ Yes ☐ No

If no, please be advised K&K may contact your employer to verify no primary insurance is in force.

INSURANCE COMPANY:_____

INSURANCE COMPANY ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

POLICY NUMBER:_____

TYPE OF PLAN:
- ☐ HEALTH MAINTENANCE ORGANIZATION (HMO)
- ☐ PREFERRED PROVIDER ORGANIZATION (PPO)
- ☐ STANDARD MEDICAL AND HOSPITALIZATION COVERAGE
- ☐ OTHER (describe)_____

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE. I UNDERSTAND THAT IT IS A CRIME TO INTENTIONALLY ATTEMPT TO DEFRAUD OR KNOWINGLY FACILITATE A FRAUD AGAINST AN INSURER BY FILING INFORMATION CONTAINING FALSE OR DECEPTIVE STATEMENTS. ANY QUESTIONS ON THIS FORM NOT ANSWERED TRUTHFULLY CAN RESULT IN A CRIME.

PARENT/GUARDIAN/FATHER SIGNATURE:_____ PARENT/GUARDIAN/MOTHER SIGNATURE:_____

DATE:_____ DATE:_____