

**COLLEGE READY.
CAREER READY.
LIFE READY.**

BOARD OF EDUCATION

Jorge E. Diaz, *Superintendent*

STUDENT ACCIDENT POLICY PROCEDURES AND RESPONSIBILITIES

The District's student accident policy is maintained by Monarch Management Corporation. The student accident policy acts as secondary insurance coverage for students that have an accident while at school resulting in an injury. There is also a voluntary policy that parents may enroll their student, at their own cost, providing 24 hour coverage.

The claims process and voluntary enrollment are all done through an on-line format. Each school is responsible for inputting individual student claims onto the insurance company's web portal. With regard to claims, please adhere to the following process:

1. Attached is a paper claim form. The first step after a claim is reported is to have the parent/guardian fill out section II and III of the paper form. You will use this information to input the claim on-line.
2. Once you have the parent information, you are ready to input the claim on-line. The online system is accessible at <https://mmc-ins.com/>. To access the site you need a username and password. The District's username and password have been previously provided to you. If you need them resent please reach out to Christine Martin in the Business Office. Use the password for all claims and keep it secure. Once you are in the system enter all the information asked for and submit the claim.
3. Please note that a student's social security is optional and can be entered if available. Providing a parent e-mail is extremely important if you can get it as the insurance company will contact the parents directly for any supplemental information or submissions.

Also attached is a brochure with information on the voluntary 24-hour coverage at the cost of the parent/guardian. Please distribute this information to the parents/guardians. This is the only option with regard to voluntary coverage. The information does reference voluntary at-school coverage and football coverage. Both are not applicable to our District. The at-school is already purchased and included with the District policy and we do not maintain any football programs. If a parent/guardian is interested in the 24 hour coverage the enrollment is on-line. The enrollment is available at http://www.mmc-ins.com/sa_enrollment.html. The parent/guardian is responsible for enrollment and payment directly with the insurance carrier. Please distribute the attached information to your students.

How to File a Medical Claim

(For Special Risk, Sports, Campers, Youth Groups, and Participant Accident Insurance Policies)

Attached is a claim form for your accident policy.
Please forward claims and questions to the following address:

WebTPA
P.O. Box 669
Grapevine, TX 76099-0669
Customer Service: (877) 563-7492
Fax: (469) 417-1989
Email: helpme@webtpa.com

Step 1: Submit a completed Notice of Claim (claim form) via either by mail or by facsimile.

The Participating Organization (not the Parent, Claimant or Agent) should:

- Fully answer each item in Part I, The Participating Organization Report.
- Read the fraud warning statement on page 3 and sign the form where indicated in Part I.

The Parent/Guardian or Adult Claimant should:

- Fully answer each item in Part II, Other Insurance Statement.
- Review Part III, Authorizations
- Read the fraud warning statement on page 3 and sign where indicated on the bottom of the Claim Form.

Step 2: Submit itemized medical bills for payment consideration to our office. If other insurance exists, include the other insurance company's corresponding Explanation of Benefits (EOBs).

HOW TO FILE A CLAIM

All information must be provided for a claim to be processed.

1. This claim form should be fully completed and submitted within 90 days from the date of accident. Be sure to answer all questions and complete the section regarding "OTHER INSURANCE STATEMENT".
2. Only one claim form for each accident needs to be submitted.
3. Once completed, make a photocopy for your records, and mail to address below:

WebTPA
P.O. Box 669
Grapevine, Texas 76099-0669
Customer Service: 877-563-7492
Fax: 469-417-1989

4. Advise all doctors / hospitals of this coverage so they may forward their itemized bills.
5. If you have already been to doctor / hospital and did not know about this coverage, send all itemized bills to address above.
6. Itemized bills should include name of doctor / hospital, complete mailing address, telephone number, date seen, what you were seen for (diagnosis) and specific itemized charges incurred. (Description of treatment including CPT codes and amount).
7. If you have other insurance, submit a claim to your other insurer. When an Explanation of Benefits is received from Primary Carrier, mail to address above along with all corresponding itemized bills and completed claim form. You must submit itemized bills which include:
 - a) HCFA-1500 (standard form used by Providers)
 - b) UB-04 or UB-92 (standard form used by Hospitals)
8. If you already paid the bill, include a paid receipt or copy of your cancelled check. Payment will be made to the Provider of Service unless a paid receipt statement accompanies the bill when claim form is submitted.
9. **Common Causes For Delays in Processing Claims**
 - a) Claim Form not fully completed or not submitted.
 - b) Balance Due, Balance Forward or Past Due statements submitted as itemized bills.
 - c) Explanation of Benefits from Primary Carrier not provided with Itemized bills.

Keep Copies of All Correspondence For Your Own Records Until Claim Has Been Processed.

PART I – PARTICIPATING ORGANIZATION STATEMENT

Policy Number:		Policyholder / Organization Name:		Event, Activity or Sport:	
Name of School:		Street Address	City	State	Zip Code
Claimant's Name (Injured Person)		Social Security Number	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	E-Mail Address
Address of Injured Person and Best Contact Phone Number (Include Area Code)					
Date and Time of Accident		Place where Accident Occurred		The injured person was a: <input type="checkbox"/> Participant <input type="checkbox"/> Staff Member <input type="checkbox"/> Other	
Dental Claims	Indicate which Teeth were Involved in the Accident	Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial			
Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)			Did Injury Result in Death? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Describe How Accident Occurred – Provide All Possible Details					

Did Accident Occur (Check Yes or No for Each of the Following):

- | | |
|---|--|
| A. During a participating organization sponsored & supervised, or sanctioned activity? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| B. On activity premises? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| C. While traveling directly and uninterruptedly to or from the activity? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| D. During a participating organization practice? <input type="checkbox"/> YES <input type="checkbox"/> NO or competition? | <input type="checkbox"/> YES <input type="checkbox"/> NO |

Signature of Participating Organization Representative	Name and Title of Participating Organization Representative	Date
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PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer or other source? ☐ YES ☐ NO

If Yes, name of insurance company: _____ Policy #: _____

Mother's (Guardian's) primary employer name, address & telephone: _____

Father's (Guardian's) primary employer name, address & telephone: _____

Are you eligible to receive benefits under any governmental plan or program, including Medicare?

☐ YES ☐ NO If yes, please explain: _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.

PART III – AUTHORIZATIONS

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. If not signed, please provide proof of payment.

SIGNATURE _____ DATE _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to **Chubb Insurance Company** or its designated administrator. A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse **United States Fire Insurance Company** to the extent of any amount collectible.

I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNATURE _____ DATE _____

CLAIM FORM FRAUD STATEMENT - FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

KANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO and PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

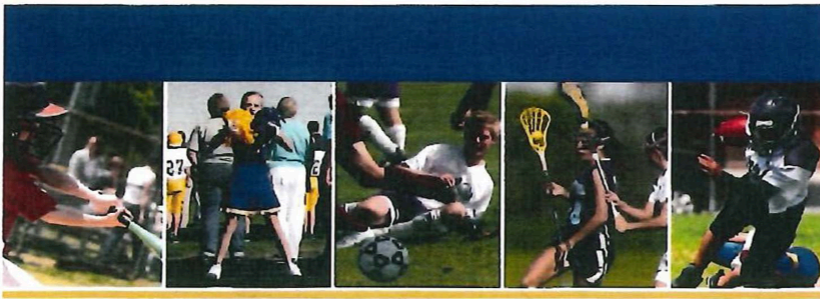
OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.



Student Accident Insurance

Monarch Management Corporation | www.mmc-ins.com | 800-662-2778

INFORMATION LETTER FOR PARENT(s)/Guardian(s)

2022-2023

SCHOOL YEAR

Supplemental student accident insurance is available for your purchase through **Monarch Management Company**.

"At-School" coverage provides accident coverage for student during the regular school session for the school year.

"24-Hour" coverage ("Around-the Clock"), protects students 24 hours a day, 7 days a week, anywhere accidents might happen anywhere in the world. This coverage provides protection from the date of enrollment until July 31, 2022. The premium (cost) of either of these optional coverages are paid "one-time only" for the year (annual payment).

Student accident insurance plans provide ACCIDENT coverage

for covered activities. The plans contain limitations and exclusions. Please carefully read the online information (or [brochure](#)) for an overview of plans. If you choose to purchase this coverage, please go on-line to purchase. This coverage is available by credit card purchase "on-line" at

www.mmc-ins.com. When enrolling on-line, the coverage

will be effective 24 hours after being received by the Company. If you do not have access to on-line enrollment please contact the campus office for an enrollment form and mail to:

Monarch Management

3201 Cherry Ridge Drive, Suite D405

San Antonio, TX 78230.

If you have claims questions, please call Customer Service at 877-563-7492, or your local agent. If you need additional information, contact your ISD.

Thank you!

El seguro de accidentes de estudiante
supplemental esta disponible para su compra por
Monarch Management Company1a.

La cobertura **"en escuela"** proporciona la cobertura de accidente para estudiantes durante la sesión escolar regular para el año escolar. Cobertura **"de 24 horas"** ("Alrededor - el Reloj"), protege a estudiantes 24 horas por día, 7 días por semana, en todas partes los accidentes podrían pasar, en cualquier parte del mundo. Esta cobertura proporciona la protección de la fecha de la inscripción hasta el 31 de julio de 2022. El premio (el coste) de cualquiera de estas coberturas opcionales es pagado "antiguo sólo" para el año (pago anual).

Los proyectos de seguro de accidentes de estudiante proporcionan la cobertura de ACCIDENTES para actividades cubiertas. Los proyectos contienen limitaciones y exclusiones. Por favor, con cuidado, lea la información en Ifnea (o folleto) para una descripción de proyectos. Si usted decide comprar esta cobertura, por favor vaya en Ifnea para comprarlo. Esta cobertura esta disponible por la compra de tarjeta de crédito "en línea" en www.mmc-ins.com. Matriculando en Ifnea, la cobertura será eficaz 24 horas después de ser recibido por la Compañía. Si usted no tiene el acceso a la inscripción en Ifnea, por favor póngase en contacto con la oficina de campus para una forma de inscripción y correo a:

Monarch Management 3201 Cherry Ridge
Drive, Suite D405 San Antonio, TX 78230.

Si usted tiene preguntas de reclamaciones, por favor llame al Servicio de Cliente en 877-563-7492. Si usted necesita más información, póngase en contacto con su ISO oficina de campus ..

Gracias!

***** **ATTENTION PARENTS** *****
***** **YOU ARE RESPONSIBLE** *****

Under State Law, school districts are not liable for injuries that occur in school. It is important to understand that the school / district "IS NOT" responsible for medical payments or bills for your child.

If your child is injured during ANY SCHOOL, ATHLETIC OR UIL SPONSORED ACTIVITY, all medical charges are "YOUR RESPONSIBILITY."

Football coverage is a separate benefit and premium. THIS INSURANCE IS PRIMARY INSURANCE TO ALL OTHER EXISTING POLICIES.

The school district has enrolled in a supplemental accident policy for the upcoming school year, which allows you the opportunity to purchase student accident insurance. You have the option of purchasing:

1. Coverage which includes UIL sponsored activities
2. Coverage without UIL sponsored activities

Please note this is a limited benefit policy and any charges above the policy limits are **YOUR RESPONSIBILITY**.

Plan Options include: (see costs below)

1. **School Time Only** which covers accidents during school time only
2. **24-Hour** which covers 24 hours a day, 365 days a year, anyplace and anytime
3. **Dental** coverage
4. **Football** coverage

If you purchase voluntary coverage it will pay in the following sequence:

- It pays primary if you do not have health insurance on your child.
- If you have primary health insurance on your child then it will pay after your health insurance has paid.
- Voluntary coverage is primary and pays first if your child is insured by CHIPS or Medicaid.

VOLUNTARY STUDENT / ATHLETIC ACCIDENT INSURANCE

Coverage	Plan A	Plan B
School Coverage & Sports Coverage (excluding Interscholastic Football)	\$71.00	\$64.00
24 Hour Coverage (excluding Interscholastic Football)	\$243.00	\$221.00
Sports Coverage (Interscholastic Football Only)	Grade 9 - \$305.00 Grades 10-12 - \$598.00	Grade 9 - \$230.00 Grades 10-12 - \$460.00

For additional information and to enroll your child in one of these Voluntary Student / Athletic Accident Insurance:

1. Go online to: www.mmc-ins.com
2. Click **ENROLL NOW**
3. Select your child's school district from the drop down menu and follow the enrollment questions. MasterCard and Visa are accepted.

Contact Monarch Management Corporation at 1-800-662-2778 with additional questions

The above is a brief description of rates and benefits available under this plan. This is not a contract, policy, or outline of coverage. All benefits are subject to maximum amounts, limits, exclusions and other policy provisions.

Visit www.mmc-ins.com for more information.

VOLUNTARY ACCIDENT INSURANCE



HOW TO ENROLL:

Enrolling online is easy and takes only a few minutes

1. Go to www.mmc-ins.com and click on **ENROLL NOW** button
2. **SELECT** the name of the **SCHOOL DISTRICT** where your child is enrolled and click **SUBMIT**
3. Enter the **RESPONSIBLE PARTY's** information and click **NEXT**
4. Enter the **STUDENT's** information and click **NEXT**
5. Select the **PLAN** in which you want your student to be enrolled and click **NEXT**
6. **Review** the plan selected for your student. Add additional students as needed.
7. **ENTER PAYMENT** information. Once you click **CONTINUE** you will receive 2 emails:
 1. Confirmation of your processed purchase
 2. Confirmation of your policy and coverage information.


NOTE: Please check spam and junk mail if you do not receive in your inbox within 24 hours of purchase.

Purchase Voluntary Insurance

Enrolling online is as easy as 1-2-3 and your child will be covered immediately. Just click here and follow the simple instructions.



Begin by finding your school district.


School District Name: 
Enter a few letters of the name...

Please enter information on the **RESPONSIBLE PARTY** for this transaction, usually the parents or guardian of the student for whom the insurance is being purchased.

 First Name
Last Name
Address

Step 2 - Student Information

Please enter information on the **STUDENT** for whom the insurance is being purchased. opportunity to enter more students on this account after each page.

 Student ID or SS #:
First Name:
Last Name:
Grade: Choose grade...

Product	AT SCHOOL
24 HOUR	
<input type="checkbox"/> 24 Hour Economy w/o sports	<input type="checkbox"/> At School Economy w/o sports
<input type="checkbox"/> 24 Hour Economy w/o sports - Dental	<input type="checkbox"/> At School Premier w/o sports
<input type="checkbox"/> 24 Hour Premier w/o sports	<input type="checkbox"/> At School Economy w/o sports - Dental
<input type="checkbox"/> 24 Hour Premier w/o sports - Dental	<input type="checkbox"/> At School Premier w/o sports - Dental
<input type="checkbox"/> 24 Hour Economy	<input type="checkbox"/> At School Economy
<input type="checkbox"/> 24 Hour Economy - Dental	<input type="checkbox"/> At School Economy + Dental
<input type="checkbox"/> 24 Hour Premier	<input type="checkbox"/> At School Premier
<input type="checkbox"/> 24 Hour Premier + Dental	<input type="checkbox"/> At School Premier + Dental
FOOTBALL	
<input type="checkbox"/> Football Grades 10-12 Economy	<input type="checkbox"/> Spring Football Economy
<input type="checkbox"/> Football Grades 10-12 Economy + Dental	<input type="checkbox"/> Spring Football Economy + Dental
<input type="checkbox"/> Football Grades 10-12 Premier	<input type="checkbox"/> Spring Football Premier
<input type="checkbox"/> Football Grades 10-12 Premier + Dental	

Step 3 - Payment Information

Please confirm your selection below. Edit to make corrections, delete the selection, or add another student. if everything is correct please enter your payment information and press continue.

Student Name	School	Product	Amount
TOTAL CHARGE:			



Cardholder Name:
Card Type: Please Select
Card Number:
Expiration Month: Select
Expiration Year: Select



VOLUNTARY INSURANCE FREQUENTLY ASKED QUESTIONS

1. Where can I get a claim form?

Claim forms are available online at www.mmc-ins.com in the bottom "FORMS" Section or you can request one to be sent to you via email or fax by calling us at 1-800-662-2778.

2. Does the Hospital / Doctor file my claim, and do I leave the claim form with the Provider?

The injured student's parents are responsible for ensuring the claim form, detailed bills and Explanations of Benefits from other insurance carriers are sent into the claims department for processing in a timely manner. The fax number and address is on the front of the claim form.

3. What if I have other insurance?

If you purchase voluntary coverage it will pay in the following sequence: It pays primary if you do not have health insurance on your child. If you have primary health insurance on your child then it will pay after your health insurance has paid. Voluntary coverage is primary and pays first if your child is insured by CHIP or Medicaid.

4. How long do I have to seek treatment and submit a claim?

Each claimant must seek treatment from a licensed physician within 90 days of the date of the accident. The claim form must be submitted within that time frame, also. The sooner the better on both treatment and claim filing.

5. Where do I find a list of participating network doctors and facilities?

If the parents have a family insurance plan, they should use the network recommended by that plan. If not, they should use the services of a MultiPlan Network provider. You may also check the MultiPlan website for providers at: <http://www.multiplan.com/search/search-2.cfm?originator=84451>

6. Who do I call to check the status of a claim?

You can call WebTPA at 877-563-7492 and select option 4 for claim status

7. Is there a deductible with this policy? No

8. Does the school insurance cover everything?

The school accident insurance is a benefit provided by your school district, and is meant to supplement personal health insurance. It has internal policy limits, and was not intended to cover every injury or expense. For example: the School Time Plan covers students during school hours the 24 Hour Plan covers students 24 hours a day, 365 days a year.

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VOLUNTARY STUDENT / ATHLETIC ACCIDENT INSURANCE

Premier Plan Options	Annual Premium	Economy Plan Options	Annual Premium
24 Hour Coverage	\$195	24 Hour Coverage – Economy	\$127
At School Coverage	\$ 93	At School Coverage – Economy	\$ 64
24 Hour Coverage – Premier (without Sports)	\$ 95	24 Hour Coverage – Economy (without Sports)	\$ 62
At School Coverage – Premier (without Sports)	\$ 20	At School Coverage– Economy (without Sports)	\$ 13
Football Coverage (10–12) - Premier	\$288	Football Coverage (10–12) - Economy	\$187
Spring Football (9-12) - Premier	\$116	Spring Football (9-12) - Economy	\$ 75

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