BRANDYWINE SCHOOL DISTRICT
1311 Brandywine Boulevard
Wilmington, DE 19809-2306

(302) 793-5000
www.brandywineschools.org

LINCOLN HOHLER
Superintendent

JOHN A. SKROBOT, III
President, Board of Education

KRISTIN PIDGEON
Vice President, Board of Education

MEMORANDUM

TO: **Parents and Guardians**

FROM: **Jason Hale, Chief Financial Officer**

DATE: **September 3, 2020**

SUBJ: **VOLUNTARY STUDENT ACCIDENT INSURANCE**

The Brandywine School District Board of Education will again this year make available to its students, a voluntary Student Accident Insurance Plan.

- Student Accident Insurance provides benefits for injuries that occur during school hours and or school sponsored and supervised activities (i.e. athletics, gym class, playground, field trips, JROTC, etc). Student accident insurance serves to reduce or completely eliminate any out of pocket expenses not paid by primary coverage including copays, deductibles, coinsurance, etc, and will pay on a primary basis in the absence of other collectible coverage

- The Board of Education in no way accepts responsibility for the program. It simply acts as an intermediary to offer a group student insurance plan for your consideration.

- If you wish to participate in the program please submit your on-line application to:

https://agadministrators.com/delk12

- The insurance program is **entirely voluntary on your part.** Please compare this program with your present coverage to determine whether or not you need to purchase it.

- **The Brandywine School District does not provide insurance for student accidents, so you are strongly encouraged to purchase this insurance if you do not have adequate coverage with another program. There have been several accidents, which resulted in large medical bills for families who did not have adequate insurance, which created a financial hardship that could have been avoided with the purchase of this insurance.**

- In the event of an accident that is covered by this policy, the child or parents should immediately notify the school. Claim forms can be found on line at https://agadministrators.com/delk12.

- All claim forms must be submitted within 90 days of the date of the accident.

Send completed claim forms to: **Tara Shockley, L&W Insurance, P.O. Box 918, Dover, DE 19903**. The claim form can also be faxed to 302.674.2909 or by email to tshockley@lwinsurance.com

- Please retain this letter and the attached information from A&G for future reference if you purchase the insurance.

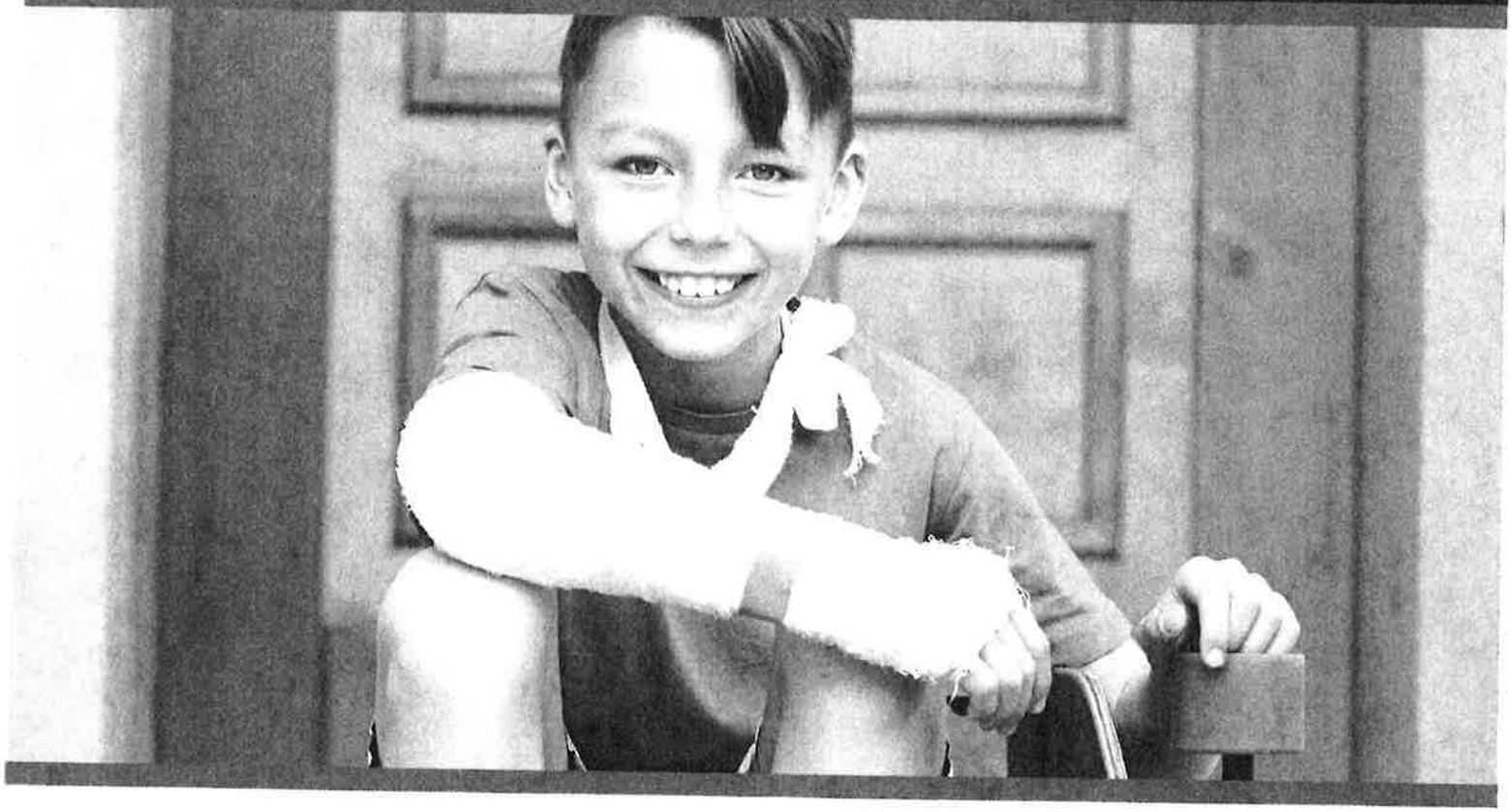
Attachment

PC: **Nurses**
Principals
Building Secretaries

It is the directive of the Board of Education that the Brandywine School District shall not discriminate in its employment practices or its educational programs and activities of students on the basis of race, creed, color, religion, national origin, age, sex, sexual orientation, domicile, marital status, disability, genetic information, veteran status, or any legally protected characteristic. All policies, regulations and practices of the District shall be guided by this directive.

SPORTS INSURANCE SPECIALISTS

K-12 Voluntary Student and Athletic Accident Insurance



AVAILABLE COVERAGE OPTIONS

Depending on which program your school provides, some or all of the following voluntary insurance products are available for purchase on a voluntary basis:

- School Time Only Student Accident Insurance
- 24-Hour Accident Coverage
- Student Dental Accident Insurance

Plans are Underwritten by
United States Fire Insurance Company

FAIRMONT SPECIALTY
A member of the Crum & Forster Enterprise

KIDS WILL BE KIDS!

1. Make sure your child is properly covered against unforeseen accidents.
2. Purchase coverage at your convenience from any computer.
3. Follow the easy step-by-step instructions and you're done in minutes!

These Voluntary Participation Student Accident Insurance Plans offered through your school can be purchased easily online at ***agadministrators.com/delk12***

A-G ADMINISTRATORS LLC P.O. Box 979, Valley Forge, PA 19482 *Ph:* (484) 321-3858 *Fx:* (484) 705-1077

Achieve Greatness!™
AGadministrators.com

A-G ADMINISTRATORS
SPORTS INSURANCE SPECIALISTS

Student Accident Claim Form

L&W INSURANCE

L & W Insurance
Attn: Tara Shockley
PO Box 918
Dover, DE 19903
FAX: 302-674-2909
EMAIL:tshockley@lwinsurance.com

Please complete and submit to L&W Insurance with itemized medical bills and primary insurance explanation of benefits.
For questions, please contact Tara Shockley.

Policyholder (School) _____

Student's Name _____
FIRST NAME MIDDLE INITIAL LAST NAME

Date of Birth _____ Sex ❑ M ❑ F SOCIAL SECURITY #

Cell Phone _____ Email Address _____

School Address _____
STREET CITY STATE ZIP

Home Address _____
STREET CITY STATE ZIP

ACCIDENT INFORMATION

Activity _____ Accident Date _____

Body Part Injured _____ Place of Accident _____

Nature of Injury — Details of What Happened _____

INSURANCE INFORMATION

Does the claimant have primary insurance? ❑ Yes ❑ No *(Attach separate sheet if necessary.)*

Insurance Company Name & Address _____

Policy Number _____ ID# _____

AUTHORIZATION

AFFIDAVIT: I verify that the statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse A-G Administrators to the extent for which A-G Administrators would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to A-G Administrators and its designees.

PAYMENT AUTHORIZATION: I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

_____ _____
STUDENT SIGNATURE *(Parent or guardian, if participant is a minor)* Date

_____ _____ _____
AUTHORIZED POLICYHOLDER REP. SIGNATURE Title Date

FRAUD WARNING: Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. For residents of the following states, please see below: California, Colorado, District of Columbia, Florida, New York, Tennessee, Texas or Virginia.

California & Texas Residents: 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 Residents: 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.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: 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.

New York Residents: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Tennessee Residents: 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.

Virginia Residents: 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.

A-G ADMINISTRATORS LLC
SPORTS INSURANCE SPECIALISTS
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Ph: **(610) 933-0800** *Fx:* **(610) 933-4122** *Email:* **claims@agadm.com**