CHRISTIAN BROTHERS SERVICES

Understanding Protecting Guiding

Send claims to:

A-G Administrators, Inc.
P.O. Box 21013
Eagan, MN 55121

Toll Free: 800.634.8628
Phone: 610.933.0800
Fax: 610.933.4122
claims@agadm.com

2024-2025 NOTIFICATION OF INJURY FORM

PART 1 Must be completed in full by an Authorized School Representative

Student Name: Last	First	MI	School
Vitrano	Bennett		300305 C
Student Address: Street	City, State Zip		**Jesuit High School of New Orleans**
1667 Soniat St.	New Orleans, La 70115		**4133 Banks Street**
Date of Birth: 4/6/20	**Grade:** K	**Sex:** M ☑ F ☐	**New Orleans, LA 70119-6883**

Description of Injury (Indicate injured body part, e.g., broken arm, sprained ankle, etc. **Must be bodily injury due to accident.**):
Slipped on wet floor and cut head requiring a staple from ER.

Accident Date: 6/30/25	Did accident occur:
Place of Accident: Bathroom Main Campus	During a school activity? Y ☑ N ☐
	During school hours? Y ☐ N ☐
	Traveling to/from school or school-sponsored activity? Y ☐ N ☐

Activity: Summer DAY CAMP

Signature of Authorized School Representative:	Title:	Date:
[signature]	Summer Camp Coordinator	7/8/25

PART 2 Must be completed in full by the Parent/Guardian

Father/Guardian Name:		Email Address:	
Name of Employer:		Phone Number:	
Mother/Guardian Name:		Email Address:	
Name of Employer:		Phone Number:	

Is student covered by a Medical Plan? Y ☐ N ☐
If yes, please provide the following information about the insurance carrier(s):

Name of Insurance Company:		Policy/Plan Number:	
Policyholder's Name:		Relationship to Student:	

Is the student eligible for Medicaid or TriCare Benefits? Y ☐ N ☐
If yes, please file for benefits under the Student Accident Plan before submitting expenses to Medicaid or TriCare.

Authorized signature(s) required on Page 2 of this form

Affidavit & Authorization

I verify that the above 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.

Signature of Parent/Guardian:	Date:

I hereby authorize any medical provider who treated or attended the above student to furnish Christian Brothers Services Student Accident Plan or its representatives any information requested. A photocopy of this authorization is to be considered valid.

Signature of Parent/Guardian:	Date:

Coverage will immediately be rescinded in the event of any person knowingly filing a statement of claim containing false, incomplete, or misleading information.

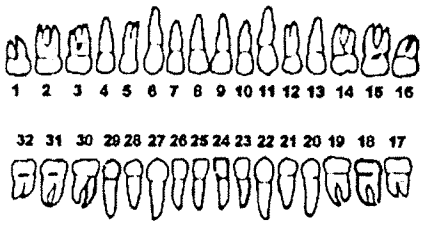
Statement of Dental Injury (Must be completed by Attending Dentist)

1. Describe exact nature of injury. Identify teeth involved in the accident and indicate on chart.

2. Nature of Treatment:

3. Condition of injured teeth prior to accident (Check all that apply.)

☐ Vital ☐ Whole ☐ Sound ☐ Filled ☐ Capped ☐ Artificial



Signed:	Date:	Degree:

Address:

Street Number City State Zip

Quick Reference Claim Procedure

School's Responsibility

- Complete Part I (school's portion) of the Notification of Injury Form in full, including signature.
- Give the Notification of Injury Form in its entirety to the parent/guardian as soon as possible for completion of the parent's portion, Part 2.
- Never give a student, parent/guardian, or medical provider a blank form.

Parent/Guardian's Responsibility (See Page 3 for detailed information)

- Complete Part II (parent/guardian portion) of the Notification of Injury Form in full, including signatures and send directly to **A-G Administrators, Inc., P.O. Box 21013, Eagan, MN 55121**.
- If you are employed, but have no insurance, we must receive a letter to that effect on the employer's letterhead.
- This form should be sent to **A-G Administrators, Inc.**, as soon as possible and must be received within 180 days of date of injury.
- Treatment must commence within thirty (30) days of the accident by a licensed physician.
- If injury is dental-related, Statement of Dental Injury must be completed by dentist.
- Send itemized medical bills and the corresponding Explanation of Benefits (EOB), or notices of denial, from primary insurance(s) within 180 days of treatment.
- Make sure the physicians and the other providers of service send all subsequent itemized bills to the address on the top of this Notification of Injury form.

Please keep Pages 3 and 4 for your records.

Christian Brothers Service Student Accident Plan

Please keep this page for your records.

The Student Accident Plan is a program designed to reimburse parents/guardians for out-of-pocket expenses incurred from hospital, physician, and other medically- necessary eligible expenses resulting from an accident to their dependent child who is a full-time registered student in a school which has agreed to participate in the Religious and Charitable Risk Pooling Trust. The Plan is an "Excess" Plan over other valid coverage, as explained below.

How To Report an Injury and Initiate the Claim Process

To qualify for reimbursement for the benefits provided, the Eligible Expenses must be for Medically-Necessary Care and exceed the amounts for which a Covered Student is entitled to reimbursement by other valid insurance or health agreements. Please reference the **Non-Duplication or Excess Provision** on page 4.

Treatment must commence within thirty (30) days of the accident by a licensed physician. All medical/dental expenses are reimbursable only if incurred within one hundred and four (104) weeks from the date of injury. All bills must be submitted within one hundred eighty (180) days of treatment.

Submit the medical expenses to all other valid coverage available to or on behalf of the Student. This includes, but is not limited to, group or individual accident and health plans, prepaid-for-service plans, HMO's, and provisions under the No-Fault Insurance Statute, including the self-insured equivalent of any minimum benefits required by law.

The following information must be received by the Plan Administrator for payment consideration:

1. Notification of Injury form provided by the school. Part 1 of this form must be completed and signed by an authorized school representative. Part 2 of this form must be completed and signed by the parent/guardian and submitted within 180 days of the injury. If injury is dental-related, Statement of Dental Injury must be completed by dentist **and...**

2. Copies of all itemized bills showing the provider's name, address, tax ID number, diagnosis and procedure codes. You can request copies of itemized bills from any provider. Receipts and statements are not valid **and**...

3. Explanation of Benefits or denial letter from the primary insurance carrier(s).

The unpaid portion of the charges will be considered for payment and paid in accordance with the terms of the Plan. Benefits can be paid to the medical provider if the parent/guardian sends written authorization to pay the provider directly; otherwise, payments will be made to the parent/guardian. If the parent/guardian(s) are employed but have no insurance, we must receive a letter to that effect on the employer's letterhead.

Send all claims to:	**A-G Administrators, Inc.** **P.O. Box 21013** **Eagan, MN 55121**	Toll Free: 800.634.8628 Phone: 610.933.0800 Fax: 610.933.4122 Email: claims@agadm.com

Questions regarding payments or claim status can be directed to 610.933.0800

Medical Coverages & Limitations

Please keep this page for your records.

Treatment must begin within 30 days of an accident by a licensed physician. Coverage is included up to the Usual, Reasonable, and Customary Charges for eligible medical care expenses incurred for medically-necessary care as a result of an accident which occurs while a student is participating in a covered activity, with a limitation of $25,000 for each accident per benefit period, not to exceed 104 weeks. Coverage includes licensed hospital, physician, nursing, lab, x-ray, and other eligible medical expenses. Hospital room and board charges are limited to the most common semi-private rate of the hospital. Dental treatment is limited up to $1,000 per tooth. Confinement, treatment, or services to diagnose, prevent, or correct craniomandibular or temporomandibular joint disorders are limited to $1,000 per accident. Orthodontics is limited to $2,500 per accident. Chiropractic and acupuncture treatment is limited to $50 per visit and $300 per covered accident. Physical Therapy and Occupational Therapy are limited to $1,500 per covered accident. Ambulance/air ambulance to nearest treatment facility is not to exceed $1,000 per accident. Durable Medical Equipment (DME) is limited to $1,500 per accident. Therapy arising out of closed head injury is limited to $2,500 per accident.

Other Benefits

- $2,500 for accidental loss of life
- $2,500 for accidental loss of both hands, both feet, both eyes, or any combination thereof
- $1,250 for the accidental loss of one hand, one foot, or one eye

Non-Duplication or Excess Provision

Reimbursements for eligible expenses are limited to expenses in excess of other valid coverage available to or on behalf of the Student for which the student and/or parent/guardian are legally obligated to pay. This includes, but is not limited to: group or individual accident and health plans, prepaid-for-service plans, HMO's, and provisions under the No-fault Insurance Statute, including the self-insured equivalent of any minimum benefits required by law.

If a student has coverage through an HMO, PPO, or similar arrangement, that plan must be used correctly or medical benefits under this Plan shall be reduced by 50%. If a Plan, representing other valid coverage available contains a similar non-duplication or excess provision of this Plan, reimbursement for eligible expenses will be shared on a 50/50 basis between the Plans.

Exclusions

This Plan does not cover expenses for (a) eyeglasses, contact lenses, or hearing aids; (b) intentionally self-inflicted injuries, suicide or any attempt thereof; committing or attempting to commit a felony; (c) injury or loss sustained due to the use of alcohol or drugs, unless taken under the advice of a physician; (d) disease or bacterial infection (except pyogenic infections due to accidental cut or wound); (e) hernia in any form; (f) accidental bodily injury occurring prior to the period of coverage; (g) illness or disease in any form; (h) any loss which is payable under any Workers' Compensation Law or Employers' Liability Law; (i) any injury caused by air travel, or injuries occurring while operating, learning to operate, or serving as a member of the crew of any aircraft, except as a fare-paying passenger on a regularly-scheduled commercial airline, or any accident where the insured is the operator and does not hold a valid motor vehicle operator's license (except in a Driver's Education Program); (j) travel in or upon any 2 or 3 wheel motor vehicle; (k) any injury that is caused by war or any act of war, or caused by taking part in a riot; (l) injuries resulting from participating in any activity which is excluded from the Coverage Plan selected by the Participating Institution including practice sessions or travel directly to or from such activities; (m) any part of a charge for confinement, treatment, or service that exceeds usual, reasonable and customary charges; (n) treatment by persons employed or retained by the participating school, or by any member of the student's immediate family; (o) re-injury or complications of a condition due to accidental bodily injury occurring prior to the effective date of the school's participation (p) injuries sustained from repetitive use or over use of a body part; (q) the Plan does not provide accident coverage to any activity which is not sponsored by the Participating Institution.

This is a partial description of the coverage provided by the Student Accident Plan.
Complete Terms & Conditions are contained in the Plan Document on file with the Participating Institution.

Neither the Plan, the Plan Sponsor, the Trustees, nor any member of the Administrator will be responsible for the false or misleading statements and/or assurances with regards to the coverages afforded under this Trust Plan that are made by the member institutions and/or its employees and representatives. Member Institutions are bound by the coverage terms and conditions as described in the Plan Document.

CHRISTIAN BROTHERS SERVICES

Student Accident Plan

1205 Windham Parkway • Romeoville, IL 60446-1679
630.378.2900 • 800.807.0300
student.accident@cbservices.org • cbservices.org

Claim Filing Procedures for Student Accident Injuries

Christian Brothers Services Student Accident Plan cannot approve payment for any medical bills without first receiving: 1) Completed accident claim form - from the school; 2) HCFA 1500/UB04 Form – from the provider; 3) Primary insurance explanation of benefits (EOB). To ensure that your claims will be processed, students are always asked to give AG Administrators' billing information (the claims company) to each medical provider PRIOR to every medical treatment and/or service for a student accident related injury. **However, if this is not done and a bill ensues, the following actions must be fulfilled by the student or provider in order to pay the claim:**

1. **Call the medical provider's Billing Department.**
   (Telephone number found on statement)

2. **Inform the Billing Department that you have an excess insurance policy.**

3. **Give the Billing Department the excess insurance policy information:**

Company Name:	AG Administrators c/o Gallagher Student
Mailing Address:	PO Box 979
	Valley Forge, PA 19482
Phone Number:	1-800-634-8628
Fax Number:	610-933-4122
ID Number:	CBS201617
Group Name:	CBS Student Accident

4. **Instruct the Billing Department to send the following to AG Administrators:**
   a. HCFA or UB04 Form (for the date(s) of service listed on statement/bill)
   b. Primary insurance EOB (for the date(s) of service listed on statement/bill)

5. **For reimbursement of bills already paid out of pocket, forward all receipts and/or proof of payment to AG Administrators along with the above documentation.**

Please Note - Cash receipts, balance due, balance forward, or past due statements are not proper documents for processing claims