TO: Superintendents of MHSAA Member Schools
FROM: John E. (Jack) Roberts, Executive Director
DATE: August 2017

SUBJECT: Insurance Benefits

As you know, MHSAA membership is entirely free of expense to member junior high/middle schools and high schools. There are no membership dues and no MHSAA postseason tournament entry fees.

Among the no-cost-to-schools benefits of MHSAA membership is the 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 6 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.

Since the 2015-16 school year, the Michigan High School Athletic Association has provided 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 follow the catastrophic accident medical insurance.

This new program intends to assure that all eligible student-athletes in MHSAA member schools in grades 6 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.

Regarding the new program, you will find enclosed . . .

• A sample letter for schools to send to each student-athlete’s parents or guardians
• Summary of Coverage
• Instructions on “How to File a Claim”
• Incident Report
• Other Insurance Questionnaire

JER/ky

Enclosures

Electronic Copies to Principals & Athletic Directors
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 6 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.

Since the 2015-16 school year, the Michigan High School Athletic Association has provided 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 6 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,

________________________
Coverage Period: 08/01/2017 – 08/01/2018
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
Accidental Death & Dismemberment $5,000
Accidental Death & Dismemberment Aggregate $250,000

Eligible Person:
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 Accidental Medical Expense benefits, the following definition of Injury applies:
A bodily injury which is:
1. Directly and independently caused by a 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.

Coverage will begin on 08/01/17, and will expire on 08/01/18.
SCHEDULE OF BENEFITS

This Schedule of Benefits shows highlights of the coverage available under the Policy. Final interpretation of all provisions and coverages will be governed by the Policy on file with Nationwide Life Insurance Company.

Policyholder: MICHIGAN HIGH SCHOOL ATHLETIC ASSOC.
Policy Number: JK000000026179403
Policy Effective Date: 09/01/17
Policy Termination Date: 08/31/18
Policy Term: 09/01/17 - 08/31/18
Eligible Class(es):

<table>
<thead>
<tr>
<th>Class</th>
<th>Number of Eligible Persons</th>
<th>Description of Eligible Persons</th>
<th>Effective Date</th>
<th>Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>ALL STUDENTS GRADES 6-12 WHO ARE AT A MEMBER SCHOOL OF THE POLICY HOLDER AND ARE PARTICIPATING IN A COVERED ACTIVITY.</td>
<td>09/01/17</td>
<td>08/31/18</td>
</tr>
</tbody>
</table>

EXCESS ACCIDENT MEDICAL LIMITS

CLASS 1
$25,000 PER INJURY
100%
1 YEAR
$5,000
$250,000

DEDUCTIBLE:
AD&SL
AD&SL AGGREGATE

Covered Activities:

Class Description of Activities
1 Participating in practice or play of interscholastic sports under the jurisdiction of the Policyholder. Interscholastic sports include: Baseball, Basketball (boys and girls), Bowling (boys and girls), Cross Country (boys and girls), Football, Golf (boys and girls), Gymnastics (girls), Competitive Cheer (girls), Ice Hockey, Lacrosse (boys and girls), Soccer (boys and girls), Softball (boys and girls), Alpine Skiing (boys and girls), Swimming and Diving (boys and girls), Tennis (boys and girls), Track and Field (boys and girls), Volleyball (girls) and Wrestling. Includes traveling directly to and from a scheduled event as a representative of the school while traveling in transportation sponsored by the school. Sideline cheerleaders are covered while traveling directly to and from interscholastic athletic events as a representative of the school while traveling in transportation sponsored by the school, and while cheering at interscholastic athletic events under the direct supervision of a school employee designated by the school.
**OTHER INSURANCE QUESTIONNAIRE**

<table>
<thead>
<tr>
<th>FATHER</th>
<th>MOTHER</th>
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</tbody>
</table>

**NAME OF CLAIMANT:**

INTERNATIONAL STUDENT: 

NAME OF INSURED:

[Radio buttons for Yes or No]

**IN PAID REIMBURSEMENT: Yes No**

**IS FATHER LEGAL RESPONSIBILITY: Yes No**

**FATHER’S NAME:**

[Blank field]

**SOCIAL SECURITY #:**

**EMPLOYED:**

[Radio buttons for Yes or No]

**SELF-EMPLOYED:**

[Radio buttons for Yes or No]

**DISABLED ON WORK OR OTHER PUBLIC ASSURANCE:**

[Radio buttons for Yes or No]

**EMPLOYER:**

[Blank field]

**EMPLOYER ADDRESS:**

[Blank field]

**PHONE:**

[Blank field]

**CONTACT PERSON:**

[Blank field]

**Do you have group medical insurance coverage through your employment?**

[Radio buttons for Yes or No]

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

**INSURANCE COMPANY:**

[Blank field]

**INSURANCE COMPANY ADDRESS:**

[Blank field]

**POLICY NUMBER:**

[Blank field]

**TYPE OF PLAN:**

[Options: Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Standard Medical and Hospital/Community Coverage, Other (specify)]

**MOTHER’S NAME:**

[Blank field]

**SOCIAL SECURITY #:**

**EMPLOYED:**

[Radio buttons for Yes or No]

**SELF-EMPLOYED:**

[Radio buttons for Yes or No]

**DISABLED ON WORK OR OTHER PUBLIC ASSURANCE:**

[Radio buttons for Yes or No]

**EMPLOYER:**

[Blank field]

**EMPLOYER ADDRESS:**

[Blank field]

**PHONE:**

[Blank field]

**CONTACT PERSON:**

[Blank field]

**Do you have group medical insurance coverage through your employment?**

[Radio buttons for Yes or No]

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

**INSURANCE COMPANY:**

[Blank field]

**INSURANCE COMPANY ADDRESS:**

[Blank field]

**POLICY NUMBER:**

[Blank field]

**TYPE OF PLAN:**

[Options: Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Standard Medical and Hospital/Community Coverage, Other (specify)]

**I UNDERSTAND THAT ALL INFORMATION PROVIDED IN THIS QUESTIONNAIRE IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY INCOMPLETE OR INACCURATE INFORMATION CAN RESULT IN DISCLAIMER PAYMENTS. FOR THIS REASON, THE RESPONSIBILITY OF RECEIVERSHIP WILL BE THE OBLIGATION OF THE INSURED TO INSURANCE IN FILL. THEREFORE, ALL INCOMES MUST BE REFLECTED.**

**I UNDERSTAND THAT IT IS A CRIME TO INTENTIONALLY ATTEMPT TO SUBMIT OR SUBMIT FALSE OR IMPROPERLY COMPLETE A FORM AGAINST AN INSURED BY FILING INFORMATION CONTAINING FALSE OR DECEPTIVE STATEMENTS. ANY QUESTIONS ON THIS FORM NOT ANSWERED TYPICALLY CAN RESULT IN A CESSION.**

**SIGNATURE:**

[Signature]

**DATE:**

[Date]

**SIGNATURE:**

[Signature]

**DATE:**

[Date]
K&K INCIDENT REPORT
Michigan High School Athletic Association
Concussion Coverage

(PLEASE PRINT)

NATURE
☐ BODILY INJURY  ☐ OTHER:

TIME & PLACE
DATE:  ___/___/___
TIME:  ___:___ AM  ___:___ PM

OF INCIDENT
EVENT NAME: ____________________________
EVENT TYPE: ____________________________
LOCATION: ____________________________

HAPPENED TO
NAME: ____________________________
SEX: ☐ Male  ☐ Female  PHONE: ___-___-_____
DATE OF BIRTH: ___/___/___  SSN: ___-___-_____
ADDRESS: ____________________________
CITY: ____________________________ STATE: ___  ZIP: ___

FUNCTION
☐ ATHLETE
☐ OTHER:

APPARENT
BODY PART: ____________________________
INJURY
CONSEQUENCE: ____________________________
ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER) OTHER:
AMBULANCE, TAKEN TO: ____________________________
CITY: ____________________________

FATALITY

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

INJURED
DESCRIPTION
DESCRIBE WHAT HAPPENED:

OTHER SCHOOL
INSURANCE
DID THE SCHOOL PROVIDE ANY OTHER INCIDENT MEDICAL COVERAGE FOR THE STUDENT?  ☐ Yes  ☐ No
IF YES, PLEASE PROVIDE THE NAME OF THE COMPANY: ____________________________

INSURED
NAME OF INSURED: MHSAA
POLICY: JSX500000028179400
ID#: ____________________________
PNAME: ____________________________
PHONE: ___-___-_____
CITY: East Lansing  STATE: MI

INSURED
NAME: Mark Lyon
CITY: East Lansing  STATE: MI

REPRESENTATIVE
MHSAA Member School Administrator  ☐ OTHER:
PHONE: ___-___-_____
NAME: ____________________________
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 SUBMITTING OR PROGRESS MAY BE DELAYED

K&KINS, OIN-1605-11/V15