ARCHDIOCESE OF NEW ORLEANS

2025-2026 Secondary (Excess) Camp Accident Insurance

Claims Filing Checklist

PLEASE NOTE – THIS POLICY IS SECONDARY TO PARENTAL/GUARDIAN MEDICAL/DENTAL INSURANCE. THERE ARE SPECIFIC REQUIREMENTS AND SPECIFIC DOCUMENTS NEEDED IN ORDER FOR A CLAIM TO BE PROCESSED AND PAID UNDER THIS POLICY. PLEASE REVIEW THE CLAIMS PACKET IN ITS ENTIRETY.

☐ 1. Archdiocese of New Orleans – Camp Director provides claim packet with their section completed of the Accident/Injury Claim Form. Please complete the sections "Your Information", "Policyholder Information", "Student Information",and "Accident Information". The form must be signed on page 2 by the Camp Director or other authorized person.

☐ 2. Parent/Guardian – Complete and sign the Accident/Injury Claim Form and submit completed and signed accident claim form to A-G Specialty Insurance. Please retain a copy for your records.

A-G Administrators
PO Box 21013
Eagan, MN 55121
Fax: (610) 933-4122 Email:
claims@agadm.com

☐ 3. See Claim Filing Instructions page for additional information regarding the claims process. Please notify all health care professionals that you have secondary coverage for the accident/ injury. You should provide them with a copy of the insurance card and claim filing instructions in this packet and instruct the provider to bill A-G Administrators directly after primary insurance has processed the claim.

SPECIALTY INSURANCE

K-12 STUDENT
ACCIDENT CLAIM FORM

Please complete and submit to A-G Specialty Insurance with itemized medical bills AND primary insurance explanation of benefits.

Send all claim forms and documents using our secure upload portal: upload.agadministrators.com
Alternatively, submit documents to claims@agadm.com.

For questions, however, please contact A-G Specialty Insurance: customerservice@agadm.com.

YOUR INFORMATION

First Name:_____ Last Name:_____

Title:_____ School/Organization Name:_____

Email Address:_____ Phone Number:_____

POLICYHOLDER INFORMATION

Policyholder (School):_____

School Address:_____
STREET CITY STATE, ZIP

STUDENT INFORMATION

Student's Name:_____
FIRST NAME MIDDLE INITIAL LAST NAME

Date of Birth:_____ Sex: ☐ M ☐ F **Parent(s) Name:**_____

Student's Phone Number (or Parent's if minor): _____

Student's EMAIL (or Parent's if minor): _____

Student's Home Address: _____
STREET CITY STATE, ZIP

ACCIDENT INFORMATION

Circumstance: ☐ Game ☐ Practice ☐ Conditioning ☐ Other (Please explain in Nature of Injury section.)

Type of Activity: ☐ Club Sport ☐ Intramural ☐ Interscholastic ☐ Non-Athletic

Activity/Sport (if athletic related):_____ 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 documents if necessary.)

Insurance Company Name:_____

Insurance Company Address:_____
STREET CITY STATE, ZIP

Policy Number: _____ ID#:_____

Is the student eligible for Medicaid or TriCare Benefits? ☐ YES ☐ NO
If yes, please file for benefits under the Student Accident Plan before submitting expenses to Medicaid or TriCare.

A-G SPECIALTY INSURANCE, LLC
PO Box 21013, Eagan, MN 55121
Ph: **(610) 933-0800** *Fx:* **(610) 933-4122** *Email:* **claims@agadm.com**

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 Specialty Insurance to the extent for which A-G Specialty Insurance 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 Specialty Insurance 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.

WARNING: New York: 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.

SCHOOL OFFICIAL SIGNATURE	DATE
PARENT / GUARDIAN SIGNATURE	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.

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

Alaska: Any 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.

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

Arkansas and Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, 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.

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 for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

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

Idaho and Indiana: 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 (for Idaho) is guilty of and (for Indiana) commits a felony. Idaho and Indiana: 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 (for Idaho) is guilty of and (for Indiana) commits a felony.

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.

Louisiana and West Virginia: 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.

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

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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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: 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 CIVIL FINES AND CRIMINAL 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: WARNING: 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.

Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto, may be subject to prosecution for insurance fraud.

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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Texas: 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

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Ph: **(610) 933-0800** *Email:* **claims@agadm.com**

2024-2025 Secondary (Excess) Camp Accident Insurance

Claims Filing Instructions

The Archdiocese of New Orleans has obtained a Secondary (Excess) Camp Accident Insurance policy in the event that a camper is injured during a sponsored/supervised camp or event and will require outside medical treatment. An Injury Claim form will be submitted on behalf the camper to A-G Administrators., the Claims Company for the accident insurance policy.

Please be advised that this coverage is excess (secondary in most situations) to all other valid and collectable insurance plans. Each camper should initially provide their primary health insurance information to each medical provider at the time of treatment, as well as the Secondary (Excess) Camp Accident insurance information. This policy is designed to cover any remaining balances of expenses related to a covered injury/accident that are not covered by the student's primary insurance (including co-pays, deductibles, coinsurance, etc.) and left to patient responsibility.

To ensure that claims are covered under the Secondary (Excess) Camp Accident Insurance campers are asked to give the billing information to each medical provider prior to every medical treatment and/or service for an Archdiocese of New Orleans sponsored/supervised activity or event, related injury. **Please present the Identification Card below.**

Camp Accident Insurance Plan
Secondary (Excess) Coverage

Archdiocese of New Orleans

Policy Effective Date: July 1, 2024
Benefits become eligible on date of injury

Payor ID: 11370

Deductible: $0 per Injury
Coverage limit: $25,000 per injury

Policy #: SB20CC-P-054471
Group #: ARCHNO2024

Front of Card

Questions: 1-800-634-8628
Email: claims@agadm.com

Eligibility is subject to change. This card is for identification purposes only and does not guarantee benefits.

This plan is excess to all other valid and collectable insurance plans. For electronic submission use **Payor ID: 11370**

For claims questions or submissions, please contact:

A-G Specialty Insurance
PO Box 21013
Eagan, MN 55121
Fax: 610-933-4122

Insurance policy is underwritten by Mutual of Omaha

Back of Card

Frequently Asked Questions

This is a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the Policy issued to the school / Policyholder. The Policy is subject to the laws of the state in which it was issued.

Q. What is "Camp Accident Insurance" and why does the Archdiocese of New Orleans have a policy?
A. The Archdiocese of New Orleans obtains Camp Accident Medical Insurance to help cover medical expenses related to a covered activity injury that results from a sponsored/supervised camp. The excess policy pays **after** any other valid/collectible insurance that the student carries (i.e. a parent's employer plan, etc.). The Camp Accident Insurance is designed to cover expenses left to the patient's responsibility on their primary insurance Explanation of Benefits (EOB), such as co-pays, deductibles, and coinsurance for eligible medical treatment.

Q. What documents are needed in order for the Camp Accident Insurance to process a claim?
A. The provider must submit the following documents to the claims company (Bollinger Inc.):

1) **Itemized Medical Bill** – The provider will either bill the claims administrator with a **HCFA 1500** or **UB04**, and it will contain the following information:
   - Provider's Name and address
   - Tax ID Number
   - Date(s) of Service
   - Diagnostic Code(s) and Procedure Code(s)
   - The Fee for Each Procedure
2) **Primary Explanation of Benefits** (EOB) – This is a statement from your primary insurance company that outlines what charges will be covered or denied, and what will be left as patient responsibility (co-pay, coinsurance, deductible, etc.).

Q. How long is a camper covered under the policy?
A. The policy has a one year benefit period from the date of a covered injury.

Q. What if a camper already paid bills that they received from a covered activity injury after primary insurance paid? Is there a way to seek reimbursement?
A. Reimbursements can be processed under this policy, however, it can require additional documentation for the camper to track down the necessary documentation once a medical provider has been paid in full. Bollinger, Inc. will need the receipt or other proof of payment in addition to the Itemized Claim (HCFA 1500 or UB04) and primary insurance EOB.

For Additional Questions Please Contact:

AG SPECIALTY INSURANCE

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Email: TSpagnoletti@agadm.com

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