



# Up to \$1,000,000 Student Accident Medical Insurance Protection



Administered By:  
**ALIVE RISK**  
Fairless Hills, PA  
(215) 946-8888



Order Form  
**AXIS Insurance Company**  
Fairless Hills, PA

Ver. 1





**To File A Claim:**

- Read and understand a claim form, and fill out [claim forms](#)
- Fill out Part A and B
- Be sure to sign and date the form
- Use appropriate codes for services received
- Send claim forms, itemized bills and receipts

**MCA Administrators, Inc.**  
**PO Box 6540**  
**Harrisburg, PA 17112**  
**(800) 427-9308**

**ENROLLMENT FORM CHECKLIST**

**Did You:**

- Fill out all appropriate information on the enrollment form (MA, H, A)
- Use appropriate codes for the service selected
- Use a H or M code for the total Premium that cancelled or order service as appropriate

**For questions, inquiries, and information contact:**

Alice    
 Fairless Hills, PA

DO NOT SEND CASH

# Enrollment Form

Please Print

Pennsylvania 2018-2019

STUDENT'S LAST NAME		
STUDENT'S FIRST NAME	MIDDLE INITIAL	
BIRTH DATE (MM/DD/YYYY)	GRADE	PHONE
HOME ADDRESS		APT#
CITY	ST	ZIP
SCHOOL SYSTEM/DISTRICT		
SCHOOL NAME		
<p>The applicant represents the information contained in this application is true and correct and forms the basis of the requested insurance. 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.</p>		
SIGNATURE OF PARENT OR GUARDIAN		DATE

My signature above certifies that I have read and understand the Student Accident Insurance Protection brochure and agree to accept the terms and conditions stated herein.

No obligation to purchase.

School Year Rate – 2018-2019 – CHECK ✓ YOUR SELECTION	
Coverage Plans	Premiums
<b>BEST BUY! 24-Hour</b>	<input type="checkbox"/> \$116.00
School Time	<input type="checkbox"/> \$30.00
Dental Accident Insurance (with either of the above plans)	<input type="checkbox"/> \$8.50

Make checks payable to:  
**Alive Risk**

**How to Enroll**

1. Decide whether you want the School time, 24-Hour Accident Protection or Dental Plan.
2. Fill out the enrollment form and enclose the form along with a check or money order made payable to the Administrator shown for the correct amount.
3. Mail envelope to A&H Lockbox; PO Box 45731; Baltimore, MD 21297  
Your cancelled check or money order stub will be your receipt and confirmation of payment.  
(Please write the student's name and school name on your check.)

MEDICAL CLAIM FORM

M...M...P.O. BOX 6540

AM A...A...

MP...H...F...M...
A...A...H...
MA...

\* HARRISBURG, PA 17112
A...A...F...A...M...
A...A...A...A...

IF PART A AND PART B ARE NOT COMPLETED IN FULL THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED.

BEFORE COMPLETING THIS FORM REFER TO CLAIM PROCEDURES AS THEY APPEAR ON THE BACK OF THIS MEDICAL CLAIM FORM

PA...A...P...H...
...dis...
...Address...
...Name...
...Practi...
...As...
...As...
...As...

PA...PA...,...P...PA...A...A...M...
...Mother...
...Address...
...Area...
...at...
...at...
...a...
...s...
...Address...
...P...
...P...

BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I, the undersigned, authorize a...
I, the undersigned, assign to...
I, the undersigned, assign to...

Address

A...H...A... PA...F... P...a...e...Medical...P...s...or...
Date Signature

1. Submit all itemized bills to both your family insurance carrier and the insurance carrier for your school/organization. These bills are generally a HICFA form (Physician) or a UB92 form (Hospital). The Physician or Hospital has an assignment of Benefits on file; which was completed on the initial treatment visit. This assignment of Benefits will be honored. If your Provider does not bill on a HICFA or UB92 Form, You will need to sign the authorization to pay Benefits to the Provider on the front of this form.
2. If your family insurance carrier is an HMO organization, CONTACT YOUR HMO PHYSICIAN AT ONCE. FAILURE TO DO SO MAY RESULT IN THE CLAIM BEING DENIED OR A SUBSTANTIALLY REDUCED BENEFIT.
3. Your family insurance carrier will send you an Explanation of Benefits (E.O.B.) listing the payments made by them. Upon receipt of the E.O.B., forward the E.O.B. along with any unpaid itemized bills and a completed claim form to the claim administrator: MCA Administrators, Inc. for processing: paid receipts and/or balance due statements are not accepted.
4. If you do not have other valid and collectible insurance (Auto, Employer Provided, Family Insurance or Self-Provided): complete the information on the claim form, sign where indicated, include all your itemized bills, receipts, etc., and forward to the claim administration for processing.

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 and subjects such person to criminal and civil penalties.

1. TO SUBMIT ADDITIONAL BILLS AFTER THE ORIGINAL FORM HAS BEEN SENT IN, BE SURE TO INCLUDE THE FOLLOWING: (A) NAME OF CLAIMANT; (B) DATE OF ACCIDENT; (C) NAME OF THE POLICYHOLDER (SCHOOL, COLLEGE OR ORGANIZATION).
2. IF YOUR FAMILY INSURANCE CARRIER IS AN HMO ORGANIZATION, CONTACT YOUR HMO PHYSICIAN AT ONCE.
3. PROOF OF LOSS IS REQUIRED WITHIN 90 DAYS FROM THE DATE OF THE ACCIDENT. YOU HAVE ONE YEAR FROM THE TIME PROOF OF LOSS WOULD HAVE BEEN REQUIRED TO FILE A CLAIM. CLAIMS SUBMITTED PAST THIS PERIOD WILL NOT BE CONSIDERED FOR PAYMENT UNDER THE POLICY.
4. AUTHORIZATION TO RELEASE MEDICAL INFORMATION (MUST BE SIGNED)
5. PAYMENT WILL BE MADE TO THE SOURCE OF SERVICE (HOSPITAL, PHYSICIAN, ETC.) UNLESS CLAIM FORM ACCOMPANYING THE BILL INDICATES OTHERWISE AT THE TIME THE CLAIM IS SUBMITTED. IF YOU PAID FOR THE SERVICES AND REIMBURSEMENT IS TO BE PAID TO YOU, PROOF OF PAYMENT WILL BE REQUIRED AT THE TIME THE CLAIM IS SUBMITTED.