TO: Superintendents
Finance Officers

FROM: Donna Lynch

DATE: September 6, 2012

RE: North Carolina School Boards Trust Errors and Omissions/ General Liability Fund (7/1/12-7/1/13 Fund Year)

NO-FAULT COVERAGE FOR MEDICAL EXPENSES ARISING OUT OF ACCIDENTAL INJURY

In 2008-2009, NCSBT first began offering no-fault coverage for medical expenses arising out of accidental injury to school districts that participate in the NCSBT Errors and Omissions/General Liability Fund. As you know, this "med pay" coverage extends to reasonable medical expenses incurred as a result of accidental injuries to students and/or school guests arising from incidents that occur on school campuses during normal school hours or during school-sponsored student events. NCSBT's med pay coverage has been a very well received addition to the program since it was added. I am very pleased to inform you that for the 2012-2013 fund year, NCSBT is once again providing this coverage to your district at no additional cost, as a member of the Errors and Omissions/General Liability Fund.

Enclosed is a copy of the *No-Fault Coverage for Medical Expenses Arising Out of Accidental Injury* Endorsement to your 2012-2013 Coverage Agreement with NCSBT, which contains the complete terms, conditions, and limitations of this coverage. While NCSBT did not change the scope of this coverage for the 2012-2013 fund year, specific exclusions were added to the Endorsement to clarify certain Medical Expenses that are not and were never intended to be covered by the program. In the Endorsement, you will see that NCSBT added specific exclusions for Medical Expenses arising out of or in connection with, in whole or in part, the following:

(1) fainting or dizziness that is not caused by specific accidental contact with another person or object,
(2) non-contact and/or overuse injuries, and
(3) teeth bleaching.

Your Board's bound coverage agreement, including a copy of this Endorsement, was recently mailed to the Superintendent.

The Medical Expense Certificate that must be submitted to NCSBT for claims made under this coverage has been revised and updated for the 2012-2013 fund year. As with last year, the Medical Expense Certificate includes Attachments which must be completed by claimants and returned to NCSBT in order for NCSBT to comply with federal reporting laws. Every claimant must complete Attachment A. If a claimant does not have or refuses to provide his or her Social Security Number on the Medical Expense Certificate, he or she *must also* fill out Attachment B. If a claimant provides his or her Social Security Number on the Medical Expense Certificate, he or she *does not* have to fill out Attachment B. The new Medical Expense Certificate and Attachments **replace all prior versions** of the Medical Expense Certificate and Attachments. Please discard any prior, outdated versions of these forms, as they will no longer meet the requirements for submitting claims under this coverage.

Enclosed for your reference are copies of the updated Medical Expense Certificate and Attachments A and B, along with "How To File A Claim", an instruction sheet for filing claims under this coverage. As you may already know, the person who sustained the injury, or his or her legal guardian in the case of a minor, must first complete the new Medical Expense Certificate and Attachments and then forward them to the Superintendent or the Superintendent's designee for completion. The Superintendent or designee must complete page 6 of the Medical Expense Certificate and submit the fully completed and executed Medical Expense Certificate and Attachments to NCSBT. When the completed Medical Expense Certificate is forwarded to NCSBT, it should include copies of all itemized medical bills, any applicable explanation of benefits statements, any accident/incident report(s) prepared by the school system, and any specific details known regarding the facts of the accidental injury. Since the NCSBT coverage is an excess coverage, all insurance or other benefits available to the claimant, including but not limited to a claimant's health insurance and any accident or student athletic coverage, must be exhausted before claims under this coverage can be considered for reimbursement or payment.

We have Spanish versions of last year's forms available on our website for your reference and are in the process of having the new forms translated. The new forms will be posted on our website in place of the old forms in the coming weeks. To access the forms, go to www.ncsba.org and click on the Risk Management drop-down menu, then select "NCSBT Members". If you have any questions regarding the Endorsement, the enclosed forms, or the procedures for submitting a claim under this coverage, please do not hesitate to contact Melody Coons (mcoons@ncsba.org, 919.747.6684) or Emily Sayed (esayed@ncsba.org, 919.747.6682) for assistance. We look forward to working with you during the 2012-2013 year.

Enclosures

ENDORSEMENT #___

NO-FAULT COVERAGE FOR MEDICAL EXPENSES ARISING OUT OF ACCIDENTAL INJURY

Subject to the terms and limits set forth below, the Fund will pay, regardless of fault, Medical Expenses incurred by or on behalf of Students and/or School Guests arising out of Accidental Injury occurring on School Campuses.

LIMITS OF COVERAGE

Per person:	$ 2,500
Per Occurrence:	$ 5,000
Coverage Period aggregate:	$ 25,000

DEFINITIONS

When used in this Endorsement, the following words and phrases are defined as set forth below:

Accidental Injury means physical injury arising out of an Occurrence on School Campuses owned or under the control of the Member School District, which is directly and independently caused by specific accidental contact with another person, structure or object. Accidental Injury does not include loss which results in whole or in part, directly or indirectly, from sickness, disease, allergy, or other bodily ailment or illness. Accidental Injury does not include injury to any person arising out of or in connection with any non-school sponsored event or activity.

Cosmetic Procedure means any type of procedure or service which is performed to improve appearance and which is not medically necessary.

Medical Expenses means reasonable expenses arising out of an Accidental Injury for necessary (1) first aid administered at the time of the Accidental Injury; (2) medical, surgical, x-ray and dental services; (3) prescription medication; (4) medical appliances supplied by a physician's office or hospital; and/or (5) ambulance, hospital, professional nursing and funeral services. The term Medical Expenses does not include expenses incurred for any psychiatric or counseling services; for any Cosmetic Procedures; or for any physiological or physical therapy services, unless such physiological or physical therapy services are prescribed by a physician.

Occurrence means an accident happening during the Coverage Period that causes Accidental Injury and that occurs during regular school hours or during a Student Event. All Accidental Injury attributable directly or indirectly to the same accident, event, conditions, cause, defect or hazard shall be considered to be one Occurrence, regardless of the time period or area over which the Accidental Injury occurs or the number of persons sustaining Accidental Injury.

School Campuses means school buildings used for classrooms, laboratories, libraries, gymnasiums, auditoriums, cafeterias, sports fields and/or similar student facilities as well as surrounding, contiguous premises owned or leased by the Member School Board. The term School Campuses does not include school warehouses, garages, office buildings or other facilities which are not routinely occupied by students.

School Guest means a person who is lawfully on the School Campus during regular school hours or during a Student Event.

Student Event means a function sponsored and scheduled by the Member School District which is under the supervision of a Member and which is for the primary benefit of Students.

EXCLUSIONS

Coverage under this Endorsement does not apply to:

(1) Medical Expenses incurred by or on behalf of Employees of the Member School District.

(2) Any expenses associated with the repair or replacement of damaged or lost eye glasses or contact lenses.

(3) Medical Expenses covered, paid or payable by workers' compensation, employee disability, occupational disease or other similar law or statute.

(4) Medical Expenses arising out of or in connection with, in whole or in part, the ownership, use, maintenance or operation of any trampoline.

(5) Medical Expenses arising out of or in connection with, in whole or in part, the ingestion, inhalation or presence of, contact with, and/or exposure to one or more Contaminants.

(6) Medical Expenses arising out of or in connection with, in whole or in part, (a) the ownership, leasing, purchasing, maintenance, operation, use, loading or unloading of any Automobile or bicycle; (b) bus assignments or the supervision of persons getting on, getting off or riding on buses; (c) the design, location or maintenance of bus routes, bus stops, roadways, signs, gates, bicycle routes, traffic flow or ingress to/egress from school property; or (d) the hiring, training, retention or supervision of any person who is involved in, or has responsibility for, any of the activities excluded from coverage under this exclusion.

(7) Medical Expenses arising out of or in connection with, in whole or in part, (a) any criminal or intentional act initiated by the person sustaining the Accidental Injury; or (b) any sexual act, sexual molestation, sexual harassment, sexual assault or sexual conduct or misconduct of any kind.

(8) Medical Expenses arising out of or in connection with animal bites or any type of injury caused by an animal.

(9) Over-the-counter medications.

(10) Medical appliances other than those obtained from a physician's office or a hospital.

(11) More than one medical consultation that is not accompanied by treatment for the Accidental Injury.

(12) Medical Expenses incurred more than one year following the date of the Accidental Injury.

(13) Medical Expenses arising out of or in connection with, in whole or in part, fainting, dizziness, or loss of consciousness which is not caused by specific accidental contact with another person, structure or object.

(14) Medical Expenses arising out of or in connection with, in whole or in part, non-contact and/or overuse injuries, including but not limited to stress fractures, ACL tears, meniscus or MCL tears, rotator cuff injuries, shin splints, tendonitis, strains, sprains, muscle pulls and tears, and blisters.

(15) Expenses arising out of or in connection with, in whole or in part, the whitening or bleaching of teeth.

EXCESS OVER OTHER INSURANCE, COVERAGE OR BENEFITS

Coverage under this Endorsement is specifically written to be excess over (1) benefits or amounts covered, paid or payable to or on behalf of the injured person under any agreement or insurance policy providing liability coverage (whether primary, excess, umbrella, or other) or medical payments coverage; (2) benefits or amounts covered, paid or payable to or on behalf of the injured party under any federal, state or local government program including but not limited to any Victims of Crime Compensation Fund, Medical Assistance Program or Medicaid Program pursuant to N.C.G.S. § 108A-54 et. seq.; and (3) benefits or amounts covered, paid or payable under an insurance policy or an agreement of medical, dental, vision, accident or other health coverage (whether group, family, individual or otherwise). No benefits will be paid under this endorsement unless and until (1) the injured Student or School Guest (or parent or guardian of such injured Student or School Guest) has properly and timely submitted claim(s) for benefits payable under all other applicable medical payment agreements; benefit programs; medical, dental, vision, accident or other health coverage; insurance policies; coverage agreements; and/or government programs; and (2) such claims have been fully and finally processed.

INCORPORATION OF TERMS

The following provisions of the Errors & Omissions/General Liability Trust Fund Coverage Agreement are incorporated herein by reference: Coverage Period; Definitions of Automobile, Claim, Contaminant, Coverage Period, Employee, Fund, Member, Member School District, and Student; Cancellation; Changes; Conflicting Statutes; Fraudulent Claims; Inspection, Audit, and Verification of Underwriting Information; Litigation against the Fund; and Subrogation.

REPORTING AND INVESTIGATION OF ACCIDENTAL INJURIES

As a condition precedent to the payment of benefits under this Endorsement, the following requirements must be met:

(1) an Accidental Injury must be reported to the Superintendent of the Member School District or the Superintendent's designee within 30 days of the Occurrence;

(2) a Fund-approved Medical Expense Certificate, signed before a notary public by the person who sustained the Accidental Injury or, if a minor, by his or her parent or legal guardian, must be fully completed and delivered to the Fund within one year of the date of the Occurrence with an incident report prepared by the Superintendent or his or her designee stating the date, time, and location of the accident and listing any witnesses or persons known to have knowledge of the accident and copies of all bills for Medical Expenses for which payment or reimbursement is sought. Any supplementary Medical Expenses not submitted with a timely filed Medical Expense Certificate which relate to medical treatment received within one year of the Accidental Injury must be submitted to the Fund within 14 months of the date of the Occurrence along with a fully completed Supplement to Medical Expense Certificate form and any other necessary supporting documentation; and

(3) all information necessary for the Fund to comply with Centers for Medicare & Medicaid Services reporting requirements, including but not limited to the full name, date of birth, gender, and social security number of the person who sustained the Accidental Injury, must be promptly provided to the Fund upon request.

As further conditions precedent to the payment of benefits under this Endorsement, the Member School District and the person who sustained Accidental Injury (or, if a minor, his or her parent or legal guardian) must cooperate with the Fund in the investigation of the Occurrence and promptly provide information and/or supporting medical records requested by the Fund; and the person who sustained Accidental Injury must submit, at the Fund's request, to physical examinations by physicians chosen by the Fund and at the Fund's expense.

OCCURRENCE-BASED COVERAGE

The no-fault coverage for medical expenses described in this Endorsement is provided on an "occurrence" basis. This means that the coverage applies to Accidental Injury resulting from an Occurrence which happens during the Coverage Period.

Neither the happening of an Occurrence during the Coverage Period nor the payment of medical expenses by the Fund as a result of such Occurrence in any way triggers liability coverage under the Errors & Omissions/General Liability Trust Fund Coverage Agreement for injury caused by the same accident. The liability coverage provided under the Errors & Omissions/General Liability Trust Fund Coverage Agreement is claims-made coverage which is triggered only by a Claim being made during the Coverage Period, pursuant and subject to all of the terms, exclusions and conditions of such Coverage Agreement.

NORTH CAROLINA SCHOOL BOARDS TRUST ("NCSBT")
NO-FAULT COVERAGE FOR MEDICAL EXPENSES

HOW TO FILE A CLAIM

NOTE: The coverage limit for covered claims under the Member School District's no-fault coverage for medical expenses through NCSBT is $2,500 per person, subject to the Member School District's per-occurrence limit and coverage period aggregate. The coverage is excess over any insurance or other benefits or amounts covered, paid, or payable to or on behalf of an injured person arising out of an Accidental Injury, including but not limited to the injured person's health insurance (with the exception of Medicare) and any accident coverage or student athletic coverage. The coverage only applies to covered treatment received within one year of the date of the Occurrence.

(Claimant Procedures)

The injured person, or if a minor, his or her parent or legal guardian, must:

- Complete the attached Medical Expense Certificate, including Attachment A, and sign the Certificate before a notary public. If the injured person does not have or refuses to provide a Social Security Number, he or she *must* fill out Attachment B.
- Submit the completed Medical Expense Certificate, including Attachments A (and B, if the injured person does not have or refuses to provide a Social Security Number), along with copies of all supporting itemized medical bills and any applicable explanation of benefits statements, to the Superintendent of the Member School District, or his or her designee.
- (Note: Failure to submit a completed Medical Expense Certificate, including all required attachments and medical documentation, will result in an inability to process the claim.)

(Member School District Procedures)

The Member School District must:

- Have the Superintendent, or his or her designee, complete page 6 of the Medical Expense Certificate.
- Submit the fully executed Medical Expense Certificate, including Attachment A (and B, if the injured person does not have or refuses to provide a Social Security Number), and copies of all supporting itemized medical bills and any applicable explanation of benefits statements to NCSBT, along with any accident/incident report prepared by the school system and a summary of any specific details known to the school system regarding the facts of the Accidental Injury. These documents should be forwarded to NCSBT to the attention of Emily Sayed, Med Pay Adjuster, P.O. Box 97877, Raleigh, NC 27624. Telephone number is (919) 747-6682. Facsimile number is (919) 841-4315. E-mail address is esayed@ncsba.org.

(Conditions of Coverage)

The following conditions must be met for coverage to be provided under the Member School District's no-fault coverage for medical expenses through NCSBT:

- An Accidental Injury must be reported to the Superintendent of the Member School District or his or her designee *within 30 days of the Occurrence.*

- A Medical Expense Certificate that has been signed by the injured person (or if a minor, his or her parent or legal guardian) and the Superintendent (or his or her designee), including

Attachment A (and B, if the injured person does not have or refuses to provide a Social Security Number), and copies of all supporting itemized medical bills and any applicable explanation of benefits statements, along with any accident/incident report and other information that the school system has regarding the Accidental Injury, must be provided to NCSBT *within one year of the date of the Occurrence* to be considered for reimbursement/payment.

NOTE: IN ORDER TO COMPLY WITH FEDERAL LAW, NCSBT MUST OBTAIN THE INJURED PARTY'S SOCIAL SECURITY NUMBER OR A COMPLETED ATTACHMENT B. FAILURE TO PROVIDE A SOCIAL SECURITY NUMBER OR COMPLETE ATTACHMENT B WILL RESULT IN A DENIAL OF BENEFITS UNDER THIS COVERAGE. IF YOU PROVIDE THE INJURED PARTY'S SOCIAL SECURITY NUMBER, YOU DO NOT HAVE TO COMPLETE ATTACHMENT B.

- The Member School District and the person who sustained the Accidental Injury, or if a minor, his or her parent or legal guardian, must cooperate with NCSBT in the investigation of the Accidental Injury and promptly provide information and/or supporting medical records requested by NCSBT. In addition, at NCSBT's request, the person who sustained the Accidental Injury must submit to physical examinations by physicians chosen by NCSBT and at NCSBT's expense.

MEDICAL EXPENSE CERTIFICATE

TO BE COMPLETED BY INJURED PARTY OR, IF INJURED PARTY IS A MINOR, BY THE MINOR'S PARENT OR LEGAL GUARDIAN

NOTICE TO INJURED PARTY OR PARENT/LEGAL GUARDIAN: This form must be submitted within one year of the accidental injury with all requested documentation, including Attachment A. You only need to complete Attachment B if the injured party does not have a Social Security Number or if you refuse to provide the injured party's Social Security Number. Your failure to provide complete information will affect recovery of benefits. You must sign this form in the presence of a notary public and return it to the Superintendent of the Member School District or the Superintendent's designee.

The Superintendent or designee must complete page 6 of this form and forward this form to the North Carolina School Boards Trust ("NCSBT"). *See additional instructions on page 6.

Accident/Injury Information

1) Injured Party's Name: First _____ Middle Init. _____ Last _____
Gender: __ Male __ Female
Address: _____
Date of Birth: _____
Social Security No.: _____

*NOTE: If the injured party does not have or chooses not to provide his or her Social Security Number, you MUST complete *Attachment B*. Failure to provide a Social Security Number or complete *Attachment B* will result in a denial of benefits under this coverage. If you provide the injured party's Social Security Number, you do not need to complete *Attachment B*.

Home Telephone No.: _____
Work Telephone No.: _____
Cell Phone No.: _____
E-mail Address: _____

2) If injured party is a minor, the minor's parent or legal guardian should complete the following:

Name of Parent (or Legal Guardian): _____
Address: _____
Home Telephone No.: _____
Work Telephone No.: _____
Cell Phone No.: _____
E-mail Address: _____

3) Date of Accident: _____

4) School Name: _____
School District: _____

5) Statement of Facts:

Tell in your own words exactly what happened. If additional space is needed, please attach a separate page.

_____
_____
_____

List of Witnesses to Accident/Incident (if there are additional witnesses, please list on a separate page and attach):

Name of Witness: _____
Address/ Tel. # of Witness: _____
_____
_____

Name of Witness: _____
Address/Tel. # of Witness: _____
_____
_____

6) Description of Injury: _____
_____
_____

7) Is treatment complete? __ Yes __ No

Insurance/Benefits Information

8) Is the injured person covered under health or medical insurance coverage? __ Yes __ No

If yes:
Name and address of health or medical coverage insurance company: _____
_____
Telephone No.: _____
Name of Insured/Covered Person: _____
Policy Number: _____
Group Number: _____
Plan Number: _____

9) Is the injured person covered under dental insurance coverage? __ Yes __ No

If yes:
Name and address of dental coverage insurance company: _____
_____
Telephone No.: _____
Name of Insured/Covered Person: _____
Policy Number: _____
Group Number: _____
Plan Number: _____

10) Is the injured person eligible for the following?:

Medicaid __ Yes __ No
Medicare __ Yes __ No If yes, HIC #_____
Other Government Medical Assistance Benefits __ Yes __ No
If yes, identify: _____

11) If the injured person is a student enrolled in the Member School District, is the injured person covered under any student accident and/or athletic coverage purchased by the parent and/or legal guardian through the Member School District? __ Yes __ No

If yes:
Name and address of insurance company: _____

_____

Telephone No.: _____
Policy Number: _____

Coverage Limit For Covered Claims

The coverage limit for covered claims is $2,500 per person, subject to the Member School District's per occurrence limit and coverage period aggregate. Medical Expense Certificates seeking reimbursement/payment in excess of the applicable coverage limit will not be considered until revised and resubmitted within the applicable coverage limit.

Excess Coverage

The no-fault coverage for necessary medical expenses under this program is excess over any other benefits available for the Accidental Injury, including but not limited to the injured party's health insurance (with the exception of Medicare) and any accident coverage or student athletic coverage. No benefits will be paid under this program in circumstances where other insurance/coverage is applicable and/or pending.

Required Medical Documentation

The following section of the Medical Expense Certificate must be fully completed in order for your claim to be considered. An incomplete Medical Expense Certificate will not be considered until fully completed and resubmitted. List and provide information below regarding all incurred medical expenses for which you are seeking reimbursement/payment (*i.e.*, expenses not covered under the insurance, plans or benefits programs identified above). **Copies of itemized medical provider statements which reflect date(s) of service, services rendered, International Classification of Diseases diagnostic codes (ICD-9 diagnostic codes), charges for services, payments and any outstanding balances must be provided with this Medical Expense Certificate in support of any request for reimbursement/payment.** Any applicable explanation of benefit statements should also be provided. If additional space is needed, please list on a separate page and attach. "See attached" is not an acceptable response to this section:

- Provider Name: _____

  Date(s) of Service: _____

  _____

  Medical Services Rendered: _____

  _____

  Original Amount of Bill: _____

  Total Amount Claimed for Payment to Provider of Outstanding Balance: $_____

  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $_____

- Provider Name: ____________________

  Date(s) of Service: ____________________
  ____

  Medical Services Rendered: ____________________
  ____

  Original Amount of Bill: ____________________

  Total Amount Claimed for Payment to Provider of Outstanding Balance: $_____

  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $_______

- Provider Name: ____________________

  Date(s) of Service: ____________________
  ____

  Medical Services Rendered: ____________________
  ____

  Original Amount of Bill: ____________________

  Total Amount Claimed for Payment to Provider of Outstanding Balance: $_____

  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $_______

- Provider Name: ____________________

  Date(s) of Service: ____________________
  ____

  Medical Services Rendered: ____________________
  ____

  Original Amount of Bill: ____________________

  Total Amount Claimed for Payment to Provider of Outstanding Balance: $_____

  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $_______

- Provider Name: ____________________

  Date(s) of Service: ____________________
  ____

  Medical Services Rendered: ____________________
  ____

  Original Amount of Bill: ____________________

  Total Amount Claimed for Payment to Provider of Outstanding Balance: $_____

  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $_______

- Provider Name: _____

  Date(s) of Service: _____
  _____

  Medical Services Rendered: _____
  _____

  Original Amount of Bill: _____

  Total Amount Claimed for Payment to Provider of Outstanding Balance: $_____

  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $_____

- Provider Name: _____

  Date(s) of Service: _____
  _____

  Medical Services Rendered: _____
  _____

  Original Amount of Bill: _____

  Total Amount Claimed for Payment to Provider of Outstanding Balance: $_____

  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $_____

This the _____ day of _____, 20__.

_____
Signature of Injured Party (if a minor, signature of parent or legal guardian)

_____
Print Name

NORTH CAROLINA
COUNTY OF _____

I, _____, a Notary Public of the County and State aforesaid, do certify that _____ personally appeared before me this day and acknowledged the due execution of the foregoing instrument.

Witness my hand and official seal this _____ day of _____, 20__.

_____
Notary Public

_____
Print Name

My Commission Expires:_____

TO BE COMPLETED BY THE MEMBER SCHOOL DISTRICT:

Does the school district purchase blanket accident coverage for all of its students? __ Yes __ No

If yes, is the coverage catastrophic coverage only? __ Yes __ No If the coverage is catastrophic coverage only, at what amount is the coverage triggered? $_____

Does the school district purchase blanket accident/athletic coverage for its middle school athletics?
__ Yes __ No

Does the school district purchase blanket accident/athletic coverage for its high school athletics?
__ Yes __ No

If the school district does purchase blanket accident coverage for middle and/or high school athletics, is the coverage catastrophic coverage only? __ Yes __ No If the coverage is catastrophic coverage only, at what amount is the coverage triggered? $_____

_____
Signature of Superintendent or Designee

_____
Print Name

_____
Title

_____
Date

(*Note: The Member School District should submit the fully executed Medical Expense Certificate to NCSBT with all supporting documentation and necessary Attachments. In addition, the Member School District should provide to NCSBT any accident or incident report the school system prepared and a summary of any specific details the school system has knowledge of regarding the Accidental Injury.)

ATTACHMENT A

HIPAA Privacy Authorization Form

(Authorization for the use or disclosure of protected health information, required by the Health Insurance Portability and Accountability Act, 45 C.F.R. §§ 160, 164.)

I, _____, on behalf of _____ ("Patient"), authorize Patient's healthcare providers to use and disclose the protected health information described below to the North Carolina School Boards Trust. This authorization for release of information covers all past, present, and future periods.

I authorize the release of Patient's complete health record: **(Circle A or B.)**

A. including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of drug or alcohol abuse; OR
B. with the exception of the following information: (Circle one or more of the following options.)
    a. Mental health records.
    b. Communicable diseases, including HIV and AIDS.
    c. Alcohol/drug abuse treatment.
    d. Other (please specify): _____.

The North Carolina School Boards Trust may use this medical information for billing or claims payment or other purposes as I may direct. This authorization shall be in force and effect until one year from the date of signing, at which time this authorization expires. I understand that I may refuse to sign this authorization and that I have the right to revoke this authorization in writing at any time. I understand that a revocation is not effective to the extent any person or entity has already acted in reliance on my authorization, or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand Patient's treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand information used or disclosed pursuant to this authorization may be disclosed by the North Carolina School Boards Trust and may no longer be protected by federal or state law.

_____

Signature of Patient or personal representative

_____

Printed name of Patient or personal representative and his or her relationship to the patient

_____

Date

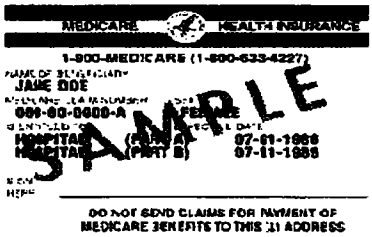
ATTACHMENT B

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	□Yes	□No
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card if available.)*		
Medicare Claim Number:	**Date of Birth (Mo/Day/Year)**	- -
Social Security Number: *(If Medicare Claim Number is Unavailable)* - -	**Sex**	□Female □Male

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) **Claim Number**

Name of Person Completing This Form If Claimant Is Unable (Please Print)

Signature of Person Completing This Form **Date**

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Section III

Claimant Name (Please Print) **Claim Number**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

Signature of Person Completing This Form **Date**

SUPPLEMENT TO
MEDICAL EXPENSE CERTIFICATE

**TO BE COMPLETED BY INJURED PARTY OR, IF INJURED PARTY IS A MINOR, BY THE MINOR'S PARENT OR LEGAL GUARDIAN*

NOTICE TO INJURED PARTY OR PARENT/LEGAL GUARDIAN: This supplement form to your original Medical Expense Certificate must be submitted within fourteen (14) months of the accidental injury with all requested documentation, including Attachment A, related to treatment received within one year of the accidental injury. Your failure to provide complete information will affect recovery of benefits. You must sign this form in the presence of a notary public and return it to the Superintendent or the Superintendent's designee. THIS FORM SHOULD ONLY BE USED TO PROVIDE ADDITIONAL INFORMATION/DOCUMENTATION TO SUPPLEMENT A MEDICAL EXPENSE CERTIFICATE WHICH YOU HAVE PREVIOUSLY COMPLETED AND PROVIDED TO THE SUPERINTENDENT OR HIS OR HER DESIGNEE REGARDING AN ACCIDENTAL INJURY.

The Superintendent or designee must sign the completed form upon receipt and forward it to the North Carolina School Boards Trust ("NCSBT").

Accident/Injury Information

1) Injured Party's Full Name: _____

2) If Injured Party is a Minor, Name of Parent (or Legal Guardian): _____

3) Date of Accident: _____

4) School Name: _____
School District: _____

5) Treatment Complete?: _____ Yes _____ No

Insurance/Benefits Information

6) Is the injured person covered under health or medical insurance coverage? __ Yes __ No

If yes:
Name and address of health or medical coverage insurance company: _____
_____
Telephone No.: _____
Name of Insured/Covered Person: _____
Policy Number: _____
Group Number: _____
Plan Number: _____

7) Is the injured person covered under dental insurance coverage? __ Yes __ No

If yes:
Name and address of dental coverage insurance company: _____

Telephone No.: _____
Name of Insured/Covered Person: _____
Policy Number: _____
Group Number: _____
Plan Number: _____

8) Is the injured person eligible for the following?:

Medicaid ___ Yes ___ No
Medicare ___ Yes ___ No If yes, HIC #_____
Other Government Medical Assistance Benefits ___ Yes ___ No
If yes, identify: _____

9) If the injured person is a student enrolled in the Member School District, is the injured person covered under any student accident and/or athletic coverage purchased by the parent and/or legal guardian through the Member School District? __ Yes __ No
If yes:
Name and address of insurance company: _____
_____
Telephone No.: _____
Policy Number: _____

Coverage Limit For Covered Claims

The coverage limit for covered claims is $2,500 per person, subject to the Member School District's per occurrence limit and coverage period aggregate.

Excess Coverage

The no-fault coverage for necessary medical expenses under this program is excess over any other benefits available for the Accidental Injury, including but not limited to the injured party's health insurance (with the exception of Medicare) and any accident coverage or student athletic coverage, if applicable. No benefits will be paid under this program in circumstances where other insurance/coverage is applicable and/or pending.

Required Medical Documentation

The following section of the Supplement to Medical Expense Certificate must be fully completed in order for your claim to be considered. An incomplete Supplement to Medical Expense Certificate will not be considered until fully completed and resubmitted. List and provide information below regarding all incurred medical expenses for which reimbursement/payment is sought (*i.e.,* expenses not covered under the insurance, plans or benefits programs identified above). **Copies of itemized medical provider statements which reflect date(s) of service, services rendered, International Classification of Diseases diagnostic codes (ICD-9 diagnostic codes), charges for services, payments and any outstanding balances must be provided with this Supplement to Medical Expense Certificate in support of any request for reimbursement/payment.** Any applicable explanation of benefit statements should also be provided. If additional space is needed, please list on a separate page and attach. "See attached" is not an acceptable response to this section:

- Provider Name: ____

  Date(s) of Service: ____
  ____

  Medical Services Rendered: ____________________________________
  ____

  Original Amount of Bill: ____________________________________

  Total Amount Claimed for Payment to Provider of Outstanding Balance: $_____

  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $_______

- Provider Name: ____

  Date(s) of Service: ____
  ____

  Medical Services Rendered: ____________________________________
  ____

  Original Amount of Bill: ____________________________________

  Total Amount Claimed for Payment to Provider of Outstanding Balance: $_____

  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $_______

- Provider Name: ____

  Date(s) of Service: ____
  ____

  Medical Services Rendered: ____________________________________
  ____

  Original Amount of Bill: ____________________________________

  Total Amount Claimed for Payment to Provider of Outstanding Balance: $_____

  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $_______

This the ______ day of _________________, 20__.

____
Signature of Injured Party (if a minor, signature of parent or legal guardian)

____
Print Name

NORTH CAROLINA
COUNTY OF _____

I, _____, a Notary Public of the County and State aforesaid, do certify that _____ personally appeared before me this day and acknowledged the due execution of the foregoing instrument.

Witness my hand and official seal this _____ day of _____, 20__.

_____
Notary Public

_____
Print Name

My Commission Expires:_____

_____

Signature of Superintendent or Designee

_____

Print Name

_____

Title

_____

Date

(*Note: The Member School District should submit the fully executed Supplement to Medical Expense Certificate to NCSBT with all supporting documentation and necessary Attachments.)