2023-24
Program Guide

:
Dissinger Reed a division of HUB International
9200 Ward Parkway, Suite 500
Kansas City, MO 64114
(913) 488-9449
www.dissingerreed.com

Program Resources

Policy Details

Insurance Policy Information

Policy Holder: USA Curling Association, Inc. and It's Member Clubs in Good Standing
Broker: Dissinger Reed
Claims Payor: A-G Administrators
Insurance Carrier: Everest Reinsurance Company

Policy#: 1BPA000104-231

Coverage Period: December 1st, 2023 – November 30th, 2024
State of Issue: Minnesota

Eligible Person: An Eligible Person is a registered USA Curling member and/or scheduled member of the group participating in the Covered Activity listed below; or a salaried full-time employee or volunteer; or a registered attendee of the Covered Activity listed below.

Hazards: (Each of the following Hazards may be included, as may coverage for Personal Deviations when shown, at the option of the Policyholder.)

Covered Activities Hazard
Sports Coverage Hazard
Supervised and Sponsored Activities Hazard
Volunteer Activities Coverage Hazard

Deductible: $500 per Covered Person
Accident Medical (Excess): $50,000
Benefit Period: 12-months (provided treatment is within 60 days)
Aggregate Per Covered Accident: $100,000
Accidental Death & Dismemberment: $20,000

Contact for Customer Service/Claims:

See next page for How to File a Claim
For claim questions or status updates, please email customerservice@agadm.com

If you need further information or have any questions, please call 610-933-0800 to speak to one of our highly qualified Customer Service Representatives between the hours of 8:30 a.m. and 6:00 p.m. E.S.T. Monday-Friday

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Program Resources

How to File a Claim

To process your claim please submit the following three pieces of information:

1. **The Claim Form:** Enables us to open a claim for the treatment of your injury. To avoid delays in claim processing please be sure all fields are completed on this form and include the policyholder's policy number. In addition, the claim form must be signed by the president of USA Curling member club.

2. **Itemized Bills:** Please ensure we are sent copies of all medical bills related to an injury, showing the name and address of the provider of service, date of service, type of service and the charges. Account statements or “balance due” statements are helpful, but do not usually contain all the information needed to process the charges.

3. **Explanation of Benefits:** If the individual has other medical insurance, all medical bills must be first submitted to the individual’s primary health insurance for their determination of eligibility. If the charges are not paid in full by the other medical insurance carrier we will need to see a copy of the “Explanation of Benefits” from that carrier prior to issuing benefits from this office.

These documents should be sent through our secure portal for submission purposes only:

https://upload.agadministrators.com

Alternatively they can be mailed or faxed to:
A-G Administrators, LLC
Claims Department
P.O. Box 21013 Eagan, MN 55121
Phone: (610)-933-0800
Fax: (610)-933-4122
Payor ID# 11370

For claim questions or status updates, please email customerservice@agadm.com

If you need further information or have any questions, please call 610-933-0800 to speak to one of our highly qualified Customer Service Representatives between the hours of 8:30 a.m. and 6:00 p.m. E.S.T. Monday-Friday

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7500 Golden Triangle Drive
Suite C09
Eden Prairie, MN. 55344

Dear Provider:

The athlete that you are treating today is a member of _____ , which is a participating member of the US Curling Association.

The US Curling Association has provided the athlete with an accident only medical plan that pays for expenses related to the care of an accident while participating in an approved event. A-G Administrators is the claims administrator for the accident only medical plan and the following information is being supplied to you in an effort to assist the claimant in obtaining maximum benefits in a timely manner.

Please submit all charges through any other primary insurance first, and then submit itemized bills (HCFA-1500 or UB-92) and the primary Explanation of Benefits to:

A-G Administrators, LLC
Claims Department
P.O. Box 21013 Eagan, MN 55121
Phone: (610)-933-0800
Fax: (610)-933-4122
Payor ID# 11370

Should you have any questions or need any additional information, please feel free to call Carlen Weiss, (913) 491-6385.

Thank You,

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A-G ADMINISTRATORS
SPORTS INSURANCE SPECIALISTS

P.O. Box 979
Valley Forge, PA 19482
610.933.0800
Fax: 610.935.2860
www.agadministrators.com

Special Risk Organization Participant Accident Claim Form

Please complete and submit to A-G Administrators with itemized medical bills and primary insurance explanation of benefits. For questions, please contact A-G Administrators.

Special Risk Organization _____

Participant's Name _____
FIRST NAME MIDDLE INITIAL LAST NAME

Date of Birth _____ Sex ☐ Male ☐ Female

LAST FOUR SOCIAL SECURITY NUMBERS ☐☐☐☐

Cell Phone _____ Email Address _____

School Address _____
STREET CITY STATE ZIP

Home Address _____
STREET CITY STATE ZIP

ACCIDENT INFORMATION

Activity _____ 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 sheet if necessary.)*

Insurance Company Name & Address _____

Policy Number _____ ID# _____

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 Administrators to the extent for which A-G Administrators 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 Administrators 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.

PARTICIPANT SIGNATURE *(Parent or guardian, if participant is a minor)* _____ Date _____

SPECIAL RISK ORGANIZATION SIGNATURE _____ Title _____ 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. For residents of the following states, please see below: California, Colorado, District of Columbia, Florida, New York, Tennessee, Texas or Virginia.

California & Texas Residents: 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.

Colorado Residents: 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 from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

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

New York Residents: 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.

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

Virginia Residents: Any person who, with the 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 may have violated state law.