Eligible Persons

All enrolled students who are participants in Policyholder supervised and sponsored club sports activities. Eligible persons include all students associated with the approved club sports per campus of the California State University System.

Covered Activities

A covered activity means a Policyholder supervised and sponsored club sports activity approved by the designated California State University, for which the Covered and Eligible Person is enrolled.

Summary of Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$30,000.00</td>
<td>Accident Medical Expense Benefit - Per Covered Accident</td>
</tr>
<tr>
<td>$100.00</td>
<td>Deductible – Student’s Responsibility</td>
</tr>
<tr>
<td>52 Weeks</td>
<td>Benefit Period</td>
</tr>
<tr>
<td>90 Days</td>
<td>Incurral Period</td>
</tr>
</tbody>
</table>

Insurance Carrier: Self-Insured

TPA: A-G Administrators, Inc.

Broker: Alliant Insurance Services, Inc.

Effective Dates: August 1, 2013 – July 31, 2014

A-G Contact Info: P.O. Box 979
Valley Forge, PA 19482
610-933-0800
610-933-4122 (fax)

Claims Contact: Dan Beery, Account Manager
dberry@agadm.com

Broker Contact: Robert Leong, Alliant Insurance Services, Inc.
rlleong@alliant.com – 415-403-1441
CSU System Wide Club Sports
Accident Medical Insurance Program

How to File a Claim

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

1. Completed and Signed Claim Form
2. Itemized Bills
3. Explanation of Benefits from your Primary Insurance Carrier

These documents should be mailed or Faxed to:
A-G Administrators, Inc.
Claims Department P.O. Box 979
Valley Forge, PA
19482
(610) 933-4122 Fax
(610) 933-0800 Phone
(800) 634-8628 (Toll Free)

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 the “other insurance” portion of the claim form is completed in full. The claim form must be signed by a school official such as a coach or athletic trainer.

2. Itemized Bills: Please include copies of all medical bills, 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 contain all the information needed to process the charges.

3. Explanation of Benefits: If you have other medical insurance, all medical bills must be first submitted to that carrier 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. If you have no primary medical insurance the need for an “Explanation of Benefits” will not be applicable to your claim.
Athletic 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.

College/University _____________________________________________

Athlete’s Name ________________________________________________

FIRST NAME                  MIDDLE INITIAL                  LAST NAME

Date of Birth ______________  Sex:  □  M  □  F  Cell Phone ____________________

Email Address ____________________________________________________

School Address ____________________________________________________

STREET                             CITY                             STATE                  ZIP

Home Address ______________________________________________________

STREET                             CITY                             STATE                  ZIP

ACCIDENT INFORMATION

Sport ___________________________ Accident Date _______________________

Circumstance:  □  Game  □  Practice  □  Conditioning  Type of Injury:  □  Intercollegiate  □  Club Sport  □  Intramural

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.

ATHLETE SIGNATURE (Parent or guardian, if participant is a minor) ___________________________ Date ______________

ATHLETIC DEPT. OFFICIAL SIGNATURE ___________________________ Title ___________________________ Date ______________

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

Athletic 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.