OHIO NEWSPAPER ASSOCIATION

DISTRICT MANAGER TRAINING SESSION

Columbus, Ohio

Wilson Gregory

Ohio Newspaper Association

Discussion Material:

1) Definition of an accident.
2) 24-Hour accident insurance policies.
3) On-Route Only accident insurance policies.
4) Who is eligible to be covered?
5) Timelines for filing claims.
6) Analysis of benefit schedules and certificates.
7) Insuring independent contractors.
8) Process that starts claim filing.

We will review this material and ask questions. It would be good to also focus the part of the Distribution Agreement that references enrollment in the insurance program.

What is the difference between a 24-Hour accident insurance policy versus an On-Route Only accident insurance policy?

- An accident is an unforeseen event creating bodily injury.
- In the 24-Hour accident insurance policy format there is a section that includes doctor's visits, x-rays, emergency room outpatient expenses, ambulance services, hospital room and board, registered nurse care, etc. ***that pays benefits*** even when an accident to an insured does not occur while on-route.
- Most programs will pay up to $500.00 unallocated maximum in aggregate.
- There is a weekly disability benefit that can be claimed if the insured is injured in an accident and is unable to perform the contracted distribution responsibilities as described in the agreement.
- On-Route Only coverage provides coverage to an insured only while the insured is On-Route. On-route activities are defined in the policy certificate.
- The common denominators among the 24-Hour policy and the On-Route Only policy are that they all have Loss of Life coverage, Weekly Disability coverage, and On-Route medical excess coverage.
- All pieces of the policy coverage are "per occurrence" not calendar year; nor policy lifetime.
- When the statement in the documents read "substitutes are covered on-route" it means that if I am the contractor of record and I cannot do my route and enlist a substitute to deliver in my absence, that substitute is covered for the ***on-route medical benefit only***.
- It does not mean that we will pay a substitute to deliver a route.

FAQ's from **INDEPENDENT CONTRACTORS** about accident insurance:

When does my coverage start and stop?

Coverage begins on the first day of a month or billing cycle. A full monthly premium or billing cycle premium has to be paid for any accident to be considered for payment.

Do I have to take a physical?

No you do not. The program features automatic enrollment.

Once I fill out the application, am I covered?

Filling out the enrollment application is just the beginning of initiating coverage. A full monthly premium or billing cycle premium will have to be received. Your premium is added to your newspaper billing invoice or deducted from your check disbursement. It is your responsibility to make sure the newspaper is doing this for you. They will then remit the premium to us.

What is the difference between an injury and an accident?

Accidents cause injuries but not every injury is the result of an accident. An accident is a defined as an "unforeseen external event causing bodily injury". If you fall on ice and fracture your leg it would be considered an accident. If you are throwing newspapers and feel a strain in your forearm or shoulder that would not be considered an accident.

I have five routes, do I have to pay five premiums to be covered?

You must only pay one premium to be covered for all routes.

I have a hernia, is it covered?

No. Hernia's in the wide realm of medical coverage is generally always excluded from "accident" policy coverage because they often times are medical conditions that surface after an extended period and are not reliably considered being caused by an accident.

Is my automobile covered for an accident?

The terms and conditions of this policy cover an individual only, not property or liability.

Is my helper automatically covered or just my substitute?

Your helper is NOT automatically covered. Your substitute is automatically covered only for the medical excess coverage. A substitute is covered while performing your contractual distribution obligations in your absence.

What is the difference between a substitute and a helper?

A substitute is an ***occasional*** replacement for you as the independent contractor of record. A substitute performs the tasks outlined in your independent contractor agreement in your ***absence.*** A helper is someone who regularly helps you with distribution, rolling newspapers, inserting supplements or changing rack locations, etc.

The District Manager did not give me any of the insurance information, where can I get it?

Feel free to phone Wilson Gregory Agency at 717.730.9777 and ask for the information, or e-mail us at info@wilsongregory.com.

INDEPENDENT CONTRACTOR ACCIDENT INSURANCE ANALYSIS FORM

TOLEDO, OHIO - ADULT INDEPENDENT CONTRACTORS

AVAILABLE BENEFITS	$9.15 PER INSURED PER MONTH		
Loss of Life	$11,000.00		
Double Dismemberment	$11,000.00		
Single Dismemberment	$5,500.00		
Physician Expense: First Visit	*		
Additional Visits	*		
Broken Teeth	*		
Maximum Benefit	*		
Physiotherapy, Chiropractic Benefit	$250/12 Mo. Period		
X-Ray Expense	*		
Anti-toxin: Each	*		
Maximum Benefit	*		
Fracture/Surgical Schedule	*		
Hospital Room & Board: Per Day	*		
# of Days	*		
Maximum Benefit	*		
Hospital Services	*		
Out-Patient/Emergency Room	*		
Registered Nurse: Per Week	*		
Maximum Benefit	*		
Ambulance	*		
Disability: Per Week	$100.00		
# of Weeks	12		
Waiting Period	7 DAYS		

ALL ABOVE REFERENCED BENEFITS ARE 24-HOUR BENEFITS AND PAY IN ADDITION TO ANY OTHER INSURANCE.

*SECTIONS PAY UP TO $500.00 UNALLOCATED MAXIMUM IN AGGREGATE FOR COVERED MEDICAL EXPENSES.

Excess On-Route Coverage	$50,000.00		
Additional On-Route Loss of Life	NONE		
Substitute Contractors	Covered On-Route		

ALL ABOVE REFERENCED EXCESS BENEFITS ARE ON-ROUTE ONLY BENEFITS AND COORDINATE WITH OTHER INSURANCE.

ONE HALF BENEFITS OVER AGE 65

EXCLUSIONS: SUICIDE, HERNIA (HOWEVER SUSTAINED), WAR (DECLARED OR UNDECLARED), DRUG OR ALCOHOL RELATED ACCIDENTS, CRIMINAL ACTIVITY, ARMED SERVICES ACTIVE DUTY, CARPAL TUNNEL SYNDROME.

WGA-20(03/01)

Wilson Gregory

WHO IS ELIGIBLE TO ENROLL

- Any independent contractor, distributor, agent, or carrier of the newspaper aged 9 to 90.
- Any helper, spouse, or children aged 9 to 90.
- Half benefits paid for individuals aged 65 & over.
- Independent contractor should enroll at the time the delivery contract is negotiated.
- If coverage is initially declined, an independent contractor may enroll anytime during their contract term.
- Independent contractor must fully complete, sign, and date the *Enrollment Application* and name a beneficiary.
- A *Certificate of Coverage* MUST BE given to the independent contractor and any helpers who enroll.
- Copies of the *Checklist/Fact Sheet*, *Enrollment Application*, or *Rejection Card* should be left with the independent contractor.
- All Enrollment Forms will be kept on file at the circulation department.

HELPER ENROLLMENT

- All helpers must complete an *Enrollment Application* and identify a beneficiary.

- The route number of the "Carrier of Record" must be listed in the top right hand corner of the *Enrollment Application.*

CASE STUDY 1

Accident – On-Route

Carrier involved in automobile accident on-route. Multiple injuries sustained.

Total amount paid: $39,584.03
Result: NO LAWSUIT

CASE STUDY 2

Accident – On-Route

Carrier involved in automobile accident on-route. Multiple injuries sustained.

Total amount paid: $112,170.70
Result: NO LAWSUIT

CASE STUDY 3

Accident – On-Route

Carrier involved in automobile accident on-route. Multiple injuries sustained.

Total amount paid: $101,252.85
Result: NO LAWSUIT

POLICY REQUIREMENTS

- Medical treatment must be sought within 10-days from the date of accident (***30-days in Pennsylvania***).

- *Claim Form* and itemized medical bills must be filed and received by the insurer within 90-days from the date of accident.

- Policy pays benefits for a period of two years from the date of accident, up to the policy limits or the recovery of the insured.

- The coverage is on a "Per Occurrence" basis, which means per accident and is not subject to annual limitations, copayments, coinsurance, or deductibles.

Aegis Security Insurance Co. ACCIDENT CLAIMS
P.O. Box 61140, Harrisburg, PA 17106-1140 • Phone 1-800-692-7338

CLAIM FORM

For Coverage Under Your Independent Contractor Accident Insurance Policy.

A. Insured must seek medical treatment within 10 days from date of Accident. (30 days in PA).
B. All Claims must be filed and received by Insurance Company within 90 days from date of Accident.
C. Newspaper always completes Part 3 and provides evidence of insurance PRIOR to issuing Claim Form to Contractor.
D. Newspaper completes last page of Claim Form in addition to Item C if Accident is reported "On-Route".
E. Contractor completes Part 1, Part 2 and Attending Physician completes Part 4.
F. For detailed filing instructions visit www.WilsonGregory.com.

"Warning: Any person 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 act, which is a crime and subject to criminal and civil penalties."

Part One
CLAIMANT'S STATEMENT

Name of Newspaper_____ (City & State) Route No._____

Name of Claimant (PLEASE PRINT)_____ (First / Middle / Last)

Social Security No._____ Independent Contractor of Record_____ Substitute Independent Contractor_____ Independent Contractor Helper_____

Street Address_____ City_____ State_____ Zip_____

Phone No. (_____) (Area Code) _____ Date of Birth_____

Date of Accident (MM/DD/YY)_____/_____/_____ Time_____ AM PM

Where did Accident happen?_____ How did Accident happen?_____

If automobile accident, attach copy of police report.

What injury did you receive?_____

If youth, do either of your parents work? Yes ☐ No ☐ If adult, do you have other work? Yes ☐ No ☐

If youth, Father's Name_____ (First / Middle / Last) Mother's Name_____ (First / Middle / Last)

FATHER'S EMPLOYER/YOUR EMPLOYER _____ NAME AND ADDRESS OF EMPLOYER _____ PHONE NO. _____

MOTHER'S EMPLOYER _____ NAME AND ADDRESS OF EMPLOYER _____ PHONE NO. _____

Have you received or are you eligible to receive benefits from any of the following:

		NAME AND ADDRESS OF COMPANY	POLICY NO
Yes ☐	No ☐	Auto Insurance	
Yes ☐	No ☐	School Insurance	
Yes ☐	No ☐	Individual Group Insurance	
Yes ☐	No ☐	State or Federal Aid	
Yes ☐	No ☐	Any other source of insurance	

List names, addresses and treatment dates of all Doctors consulted for this injury:
Doctor's Name Street Addresses Cities and States

List ALL Dates of Treatment
At Doctor's Office_____
At Hospital_____

Were you treated at the hospital for this injury? Yes_____ No_____

If Yes
Name of Hospital_____
Address of Hospital_____ City_____ State_____
Date Admitted_____ Date Discharged_____

Did you lose any time from your newspaper route? Yes_____ No_____ If yes, attach physician orders

If Yes — From Month_____ Date_____ Year_____ At_____ o'clock ____M
To Month_____ Date_____ Year_____ At_____ o'clock ____M

If you did not return to your newspaper route, when did you resume other activities?
Month_____ Date_____ Year_____ At_____ o'clock ____M

ATTACH BILLS HERE

Part Two

AUTHORIZATION STATEMENT – Claimant must complete along with Part One.

THIS MUST BE SIGNED AND RETURNED WITH COMPLETED CLAIM FORM
AUTHORIZED TO OBTAIN INFORMATION

TO PHYSICIANS OR PRACTITIONERS, HOSPITAL, CLINICS, PHARMACISTS, INSURANCE COMPANIES, MEDICAL INFORMATION BUREAU, EMPLOYERS AND OTHER PERSONS OR INSTITUTIONS: This authorizes you to give Aegis Security Insurance Company or its authorized representative engaged to assist in the evaluation of the claim of the undersigned, any information, data or records you have regarding employment and any condition (including records pertaining to psychiatric, drug or alcohol use and history, and any disability). I understand that such information is confidential and as such Aegis Security Insurance Company is requested not to furnish any such information to anyone other than the aforementioned without written authorization from me. I understand that any information obtained pursuant to this authorization will be used to evaluate this claim and may be transferred to any agency or individual engaged or contracted by Aegis Security Insurance Company to assist. This authorization is valid unless I revoke it by writing Aegis Security Insurance Company. I understand I have the right to request a copy of this authorization. A photocopy of this authorization may be accepted by you.

_____
DATE

_____
SIGNATURE OF INDEPENDENT CONTRACTOR/CLAIMANT

_____
SIGNATURE OF PARENT (if independent contractor is a minor)

_____
Print Name

_____
Print Name

"Warning: Any person 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 act, which is a crime and subject to criminal and civil penalties."

Part Three

TO BE COMPLETED BY THE NEWSPAPER

Name of Regular Carrier_____

Regular Carrier Became insured on (Date)_____

Policy No._____ Acct. #_____

Check One: ☐ Youth Independent Contractor ☐ Adult Independent Contractor
☐ Helper Independent Contractor

If Claim is being filed for a Substitute Independent Contractor, check here ☐

Comment_____

Name of Newspaper_____ City_____

By_____ Date_____
Authorized Signature only as contained on authorized signature card.

ATTENTION

TO EXPEDITE PAYMENT OF THIS CLAIM AND MAKE SURE IT IS PAID CORRECTLY PLEASE CHECK YOUR BILLING RECORDS AND INDICATE THE WEEKLY OR MONTHLY PREMIUM THIS CARRIER IS PAYING.

WEEKLY $_____ . _____ MONTHLY $_____ . _____ ACCT. #_____

As proof of insurance in force, a copy of the newspaper circulation billing statement covering the date of accident must accompany this claim form.

THANK YOU

Part Four

ATTENDING PHYSICIAN'S STATEMENT – Must be completed by the attending physician or if Independent Contractor lost time from the route.

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

TYPE OR PRINT ☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ OTHER

PATIENT & INSURED (SUBSCRIBER INFORMATION)

1. PATIENT'S NAME (First name, middle initial, last name)	2. PATIENT'S DATE OF BIRTH / /	3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)	5. PATIENT'S SEX MALE ☐ ☐ FEMALE	6. INSURED'S ID No or MEDICARE No (include any letters)
	7. PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	
9. OTHER HEALTH INSURANCE COVERAGE – Enter Name of Policyholder, Plan Name, Address and Policy or Medical Assistance Number	10. WAS CONDITION RELATED TO A) PATIENT'S EMPLOYEMENT YES ☐ ☐ NO B) AN AUTO ACCIDENT YES ☐ ☐ NO	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing) I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of Medicare Champus Benefits Either to Myself or the Party Who Accepts Assignment Below SIGNED DATE		13. I Authorize Payment of Medical Benefits to Undersigned Physician or Supplier for service described below SIGNED (Insured or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF	ILLNESS (FIRST SYMPTON) OR INJURY ACCIDENT OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ ☐ NO
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM THROUGH		DATES OF PARTIAL DISABILITY FROM THROUGH
19. NAME OF REFERRING PHYSICIAN			20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)			22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ ☐ NO CHARGES

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATED DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC OR DX CODE

1.
2.
3.
4.

24. A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(Explain unusual services or circumstances)	D DIAGNOSIS CODE	E CHARGES	F

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (Read back before signing) SIGNED DATE		27. TOTAL CHARGE	28 AMOUNT PAID	29 BALANCE DUE
	30. YOUR SOCIAL SECURITY NO.	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		
32. YOUR PATIENT'S ACCOUNT NO.	33. YOUR EMPLOYER I D NO.	I D NO		

*PLACE OF SERVICE CODES

1-(H)-INPATIENT HOSPITAL	4-(H)-PATIENT'S HOME	7-(NH)-NURSING HOME	O-(OL)-OTHER LOCATIONS
2-(OH)-OUTPATIENT HOSPITAL	5-DAY CARE FACILITY (PSY)	8-(SNF)-SKILLED NURSING FACILITY	A-(IL)-INDEPENDENT LABORATORY
3-(O)-DOCTOR'S OFFICE	6-NIGHT CARE FACILITY (PSY)	9-AMBULANCE	B-OTHER MEDICAL/SURGICAL FACILITY

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74

SPECIAL "ON ROUTE" ACCIDENT REPORT FORM

MUST BE COMPLETED BY AN AUTHORIZED NEWSPAPER REPRESENTATIVE TO DETERMINE WHETHER ACCIDENT WAS OR WAS NOT "ON ROUTE"

Date Completed_____

1. Complete for ANY accident reported to have happened "ON ROUTE". That is, delivering, collecting, soliciting on an established route, or while on a company approved trip.	2. **IMPORTANT:** No claim can be paid as "ON ROUTE" unless this form has been properly completed in detail and signed by the authorized newspaper representative.

A. Name of Independent Contractor Newspaper Carrier_____ Age_____

B. Address_____ Route No._____

C. What are the boundaries of the route?_____

_____

D. When does Independent Contractor regularly deliver papers? From_____ o'clock____M to_____ o'clock____M

E. At what location does Independent Contractor receive papers?_____
(STREET AND NUMBER OR CORNER)

F. When did this accident happen? Date_____ At_____o'clock____M

G. Where?_____

H. How far is that from Independent Contractor's home?_____

I. What was the Independent Contractor doing at the time of injury?_____

J. How did the accident happen?_____

K. Name of subscriber called on just before the accident?_____

Address?_____

L. How far is this from place where accident happened?_____

M. What would have been Independent Contractor's next call if accident had not happened?_____

_____

Address?_____

N. How far is this from place where accident happened?_____

O. Names and addresses of all persons and witnesses from whom you received the above information._____

_____

_____

P. I hereby affirm that on (date)_____, I personally investigated this accident and certify that the above is a complete and accurate statement of the facts and the Independent Contractor policy-certificate was issued at the time of contracting on_____.

Signature of person making
the investigation _____ Title_____

"Warning: Any person 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 act, which is a crime and subject to criminal and civil penalties."

LETTER OF RECOMMENDATION

Date_____

I have carefully considered all the facts in connection with this claim and hereby recommend it be paid. Kindly review claim file and advise if you need any additional information to make payment.

NOTE: Do not sign this Letter of Recommendation if it was not an "ON ROUTE" accident.

Signed _____
Circulation Director or Manager

Name of Newspaper_____

Aegis Security Insurance Co. ACCIDENT CLAIMS
P.O. Box 61140, Harrisburg, PA 17106-1140 • Phone 1-800-692-7338

CLAIM BLANK

For benefits under your Independent Contractor newspaper carrier accident insurance policy.

A. All claims must be filed and received by the insurance company within 90 days from the date of Accident.
B. Insured must complete Parts I and II.
C. Attending Physician must complete Part IV.
D. Newspaper must complete Part III; and
E. Newspaper must complete Special "On-Route" Accident Report, if applicable.
F. Mail itemized bills and completed claim form to the indicated address above.

"Warning: Any person knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claims containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and subject to criminal and civil penalties."

Part One
CLAIMANT'S STATEMENT

Name of Newspaper Harrisburg Patriot News, Harrisburg, PA (City & State) Route No. # 241-B

Name of Claimant (PLEASE PRINT) Jane (First) Alice (Middle) Doe (Last)

Social Security No. 123-45-1234 Independent Contractor of Record √ Substitute Independent Contractor ____ Independent Contractor Helper ____

Street Address 2309 Market Street City Camp Hill State PA Zip 17011

Phone No. (717) 730-9777 (Area Code) Date of Birth January 15, 1950

Date of Accident (MM/DD/YY) 01 / 18 / 2002 Time 5:30 (AM) PM

Where did Accident happen? 1203 10 th St. How did accident happen? I tripped on the curb. I fell and broke my arm.

If automobile accident, attach copy of police report.

What injury did you receive? Broken arm.

If youth, do either of your parents work? Yes ☐ No ☐ If adult, do you have other work? Yes ☑ No ☐

If youth, Father's Name ____ (First Middle Last) Mother's Name ____ (First Middle Last)

FATHER'S EMPLOYER/YOUR EMPLOYER — NAME AND ADDRESS OF EMPLOYER — PHONE NO.

MOTHER'S EMPLOYER — NAME AND ADDRESS OF EMPLOYER — PHONE NO.

Have you received or are you eligible to receive benefits from any of the following:

		NAME AND ADDRESS OF COMPANY	POLICY NO
Yes ☐	No ☐	Auto Insurance	
Yes ☐	No ☐	School Insurance	
Yes ☑	No ☐	Individual Group Insurance BC/BS Camp Hill, PA	11-111
Yes ☐	No ☐	State or Federal Aid	
Yes ☐	No ☐	Any other source of insurance	

List names, addresses and treatment dates of all Doctors consulted for this injury:

Doctor's Name	Street Addresses	Cities and States
Robert Little, MD	1900 Market St.	Camp Hill, PA

List ALL Dates of Treatment
At Doctor's Office 1-19-02, 1-21-02
At Hospital 1-21-02

Were you treated at the hospital for this injury? Yes √ No ____

If Yes: Name of Hospital HOLY SPIRIT HOSPITAL; Address of Hospital 122 Erford Rd. City Camp Hill State PA; Date Admitted 1-21-02 Date Discharged 1-23-02

Did you lose time from your newspaper route? Yes √ No ____ If yes, attach physician orders

If From Month January Date 19 Year 2002 At 6 o'clock A M

Yes To Month ____ Date ____ Year ____ At ____ o'clock ____ M

If you did not return to your newspaper route, when did you resume other activities?
Month Undetermined Date ____ Year ____ At ____ o'clock ____ M

ATTACH BILLS HERE

CLAIMANT MUST ALSO COMPLETE PART TWO ON NEXT PAGE. **CL1 01/2004**

Part Two

AUTHORIZATION STATEMENT – Claimant must complete along with Part One.

THIS MUST BE SIGNED AND RETURNED WITH COMPLETED CLAIM FORM

AUTHORIZED TO OBTAIN INFORMATION

TO PHYSICIANS OR PRACTITIONERS, HOSPITAL, CLINICS, PHARMACISTS, INSURANCE COMPANIES, MEDICAL INFORMATION BUREAU, EMPLOYERS AND OTHER PERSONS OR INSTITUTIONS: This authorizes you to give Aegis Security Insurance Company or its authorized representative engaged to assist in the evaluation of the claim of the undersigned, any information, data or records you have regarding employment and any condition (including records pertaining to psychiatric, drug or alcohol use and history, and any disability). I understand that such information is confidential and as such Aegis Security Insurance Company is requested not to furnish any such information to anyone other than the aforementioned without written authorization from me. I understand that any information obtained pursuant to this authorization will be used to evaluate this claim and may be transferred to any agency or individual engaged or contracted by Aegis Security Insurance Company to assist. This authorization is valid unless I revoke it by writing Aegis Security Insurance Company. I understand I have the right to request a copy of this authorization. A photocopy of this authorization may be accepted by you.

January 31, 2002

DATE

Jane Doe

SIGNATURE OF INDEPENDENT CONTRACTOR/CLAIMANT

SIGNATURE OF PARENT (if independent contractor is a minor)

Jane Doe

Print Name

Print Name

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Part Three

TO BE COMPLETED BY THE NEWSPAPER PRIOR TO ISSUING TO CONTRACTOR

Name of Regular Carrier Jane Doe

Regular Carrier Became insured on (Date) 12/1/01

Policy No. SGL-23000 Acct. # SRX-97084

Check One: ☐ Youth Independent Contractor ☑ Adult Independent Contractor

☐ Helper Independent Contractor

If Claim is being filed for a Substitute Independent Contractor, check here ☐

Comment

Name of Newspaper PATRIOT-NEWS City Harrisburg, PA

By Joyce Connell, Circulation Office Mgr. Date 1/31/02

Authorized Signature only as contained on authorized signature card.

ATTENTION

TO EXPEDITE PAYMENT OF THIS CLAIM AND MAKE SURE IT IS PAID CORRECTLY PLEASE CHECK YOUR BILLING RECORDS AND INDICATE THE WEEKLY OR MONTHLY PREMIUM THIS CARRIER IS PAYING.

WEEKLY $_____._____ MONTHLY $ 7.50 **ACCT.#** 97084

As proof of insurance in force, a copy of the last paper bill on which premium was charged or check disbursement showing premium deducted must accompany this claim form.

THANK YOU

Part Four

ATTENDING PHYSICIAN'S STATEMENT – Must be completed by attending physician or if Independent Contractor lost time from the route.

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

TYPE OR PRINT ☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ OTHER

PATIENT & INSURED (SUBSCRIBER INFORMATION)

1. PATIENT'S NAME (First name, middle initial, last name)	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME (First name, middle initial, last name)
Jane Doe	01 / 15 / 1950	Jane Doe
4. PATIENT'S ADDRESS (Street, City, State, ZIP code) 2309 Market St. Camp Hill, PA 11-1111	5. PATIENT'S SEX MALE [ ] FEMALE [X] 7. PATIENT'S RELATIONSHIP TO INSURED SELF [X] SPOUSE [ ] CHILD [ ] OTHER [ ]	8. INSURED'S ID No or MEDICARE No (include any letters) 123-45-1234
9. OTHER HEALTH INSURANCE COVERAGE – Enter Name of Policyholder, Plan Name, Address and Policy or Medical Assistance Number BC/BS Camp Hill, PA 11-1111	10. WAS CONDITION RELATED TO A) PATIENT'S EMPLOYMENT YES [ ] NO [X] B) AN AUTO ACCIDENT YES [ ] NO [ ]	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – (Read back before signing) I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of Medicare Champus Benefits Either to Myself or the Party Who Accepts Assignment Below SIGNED Jane Doe Date 1/31/02		13. I Authorize Payment of Medical Benefits to Undersigned Physician or Supplier for service described below SIGNED (Insured or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF 01 / 19 / 02	ILLNESS (FIRST SYMPTOM) OR INJURY ACCIDENT OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION 01 / 19 / 02	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO [X]
17. DATE PATIENT ABLE TO RETURN TO WORK UNDETERMINED	18. DATES OF TOTAL DISABILITY FROM 1/21/02 | THROUGH APPROXIMATELY 6 WKS		DATES OF PARTIAL DISABILITY FROM | THROUGH
19. NAME OF REFERRING PHYSICIAN Robert Little, MD			20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED | DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office) ER. Phys Holy Spirit Hospital			22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [ ] CHARGES

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATED DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC OR DX CODE

1. 824.0
2.
3.
4.

24. A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGE	F
1/19/02						
1/21/02			See attached itemized bills			
			for complete breakdown			

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (Read back before signing) SIGNED R Little DATE 1/31/02		27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
	30. YOUR SOCIAL SECURITY NO.	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO. Robert Little, MD 1900 Erford Road Camp Hill, PA 17011 I D NO		
32. YOUR PATIENT'S ACCOUNT NO. JD 204-67-01	33. YOUR EMPLOYER ID NO.			

*PLACE OF SERVICE CODES

1-(H)-INPATIENT HOSPITAL	4-(H)-PATIENT'S HOME	7-(NH)-NURSING HOME	O-(OL)-OTHER LOCATIONS
2-(OH)-OUTPATIENT HOSPITAL	5-(DAY CARE FACILITY (PSY)	8-(SNF)-SKILLED NURSING FACILITY	A-(IL)-INDEPENDENT LABORATORY
3-(O)-DOCTOR'S OFFICE	6-NIGHT CARE FACILITY (PSY)	9-AMBULANCE	B-OTHER MEDICAL/SURGICAL FACILITY

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74

SPECIAL "ON ROUTE" ACCIDENT REPORT FORM

MUST BE COMPLETED BY AN AUTHORIZED NEWSPAPER REPRESENTATIVE TO DETERMINE WHETHER ACCIDENT WAS OR WAS NOT "ON ROUTE"

Date Completed January 31, 2002

1. Complete for ANY accident reported to have happened "ON ROUTE". That is, delivering, collecting, soliciting on an established route, or while on a company approved trip.	2. **IMPORTANT**: No claim can be paid as "ON ROUTE" unless this form has been properly completed in detail and signed by the authorized newspaper representative.

A. Name of Independent Contractor Newspaper Carrier Jane Doe Age 52

B. Address 2309 Market St. Camp Hill, PA 17011 Route No. 241-B

C. What are the boundaries of the route? 900 Block of 9th Street to 1300 Block of 12th St.

D. When does Independent Contractor regularly deliver papers? From 4:30 o'clock AM to 6:00 o'clock AM

E. At what location does Independent Contractor receive papers? At Distribution Center
(STREET AND NUMBER OR CORNER)

F. When did this accident happen? Date January 18, 2002 At 5:30 o'clock AM

G. Where? 1203 10th St.

H. How far is that from Independent Contractor's home? 2 miles

I. What was the Independent Contractor doing at the time of the injury? Delivery of papers to subscribers

J. How did the accident happen? Carrier tripped on curb, fell and broke her arm.

K. Name of subscriber called on just before the accident? John Denver
Address? 1206 10th St.

L. How far is this from place where accident happened? 200 feet, next house, across the street.

M. What would have been Independent Contractor's next call if accident had not happened? 1210 10th St
Address?

N. How far is this from place where accident happened? 200 feet

O. Names and addresses of all persons and witnesses from whom you received the above information. Jane Doe, Carrier of Record, and Robert Little, MD

P. I hereby affirm that on (date) 1/31/02, I personally investigated this accident and certify that the above is a complete and accurate statement of the facts and the Independent Contractor policy-certificate was issued at the time of contracting on 11/22/01.

Signature of person making the investigation David Smith Title District Sales Manager

"Warning: Any person knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claims containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and subject to criminal and civil penalties."

LETTER OF RECOMMENDATION

Date 1/31/02

I have carefully considered all the facts in connection with this claim and hereby recommend it be paid. Kindly review claim file and advise if you need any additional information to make payment.

NOTE: Do not sign this Letter of Recommendation if it was not an "ON ROUTE" accident.

Signed John Miller Circulation Director
Circulation Director or Manager

Name of Newspaper HARRISBURG PATRIOT NEWS

Part One:
Independent Contractor (Carrier) must complete all questions. Be sure to list any other insurance information; including Auto, School, Individual Group, State, or Federal Aid.

Part Two:
Independent Contractor must sign and date authorization to obtain information. If the Independent Contractor is a minor, the Parent or Legal Guardian must sign the authorization.

Part Three:
To be completed by an authorized employee of the Newspaper. Entire section must be completed with an authorized signature, the premium amount paid, policy and account numbers. Additionally, the following information is required: **A copy of the newspaper premium billing statement for the period covering the date of accident.**

Part Four:
This section is to be completed by the attending physician. If disability is being claimed, box #18 must be completed with from/to dates.

If the accident happened while the carrier was on route, the Special "On-Route" Accident Report Form on the back of the accident claim form must be completed in full by the insured Independent Contractor and then signed and dated by an authorized employee of the Newspaper.

The Letter of Recommendation portion at the bottom of this section must be signed and dated by an authorized employee of the Newspaper.

Forward the completed Claim form to:

Aegis Security Insurance Company
Accident Claims Dept.
P.O. Box 61140
Harrisburg, PA 17106-1140

If your accident is motor vehicle related, a copy of the police report and declaration page from your auto insurance policy must be submitted with the claim form.

Please note: Treatment for injury(s) due to the direct and independent result of the accident must be received with ten (10) days [thirty (30) days in Pennsylvania] from the date of accident and the claim form must be received in our office within ninety (90) days from the date of the accident.

All charges incurred for treatment received due to the direct and independent result of the accident should be sent to the above address. **Please note: we do not pay claims from provider's statements.** The following standard billing forms are acceptable: HCFA1500 or UB-92 claim forms. If there is other insurance, a copy of the Explanation of Benefits (EOB) is also required.

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Unlike most discount plans, your Wilson Gregory discount drug plan provides discounts on all FDA-approved prescription drugs. There are no limited drug lists. You can have the drug that works best for you.

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Your Discount Drug Card is widely accepted at **over 54,000 participating pharmacies** across the United States. If your favorite pharmacy is not enrolled, ask them to contact member services at **1-800-974-3454.**

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This plan applies to **your entire family**, because everyone deserves to save. Any family member can **present this card every time** they need to fill a prescription for instant savings. There are absolutely no restrictions or limitations.

Your card is active. To **save**, simply detach along perforated edge and present at a participating pharmacy.

Wilson Gregory AGENCY INC.

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- Get retail pharmacy drug pricing
- Find and price equivalent alternative drugs that may cost you less
- Get mail-order drug pricing
- Download and print a mail-order application
  Mail-order info: 1-800-974-3454

Your card is accepted here:

chains

- Albertsons
- Costco
- CVS
- Eckerd
- K-mart
- Kroger
- Giant
- Rite Aid
- Safeway
- Weis
- Target
- Wal-Mart
- Walgreens
- Winn-Dixie

associations

- Access Health
- United Drugs
- Leader

independents

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Void where prohibited. Process all prescriptions electronically.

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Pharmacy Help Desk: 1-800-481-0605