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 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

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

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.

<table>
<thead>
<tr>
<th>Excess On-Route Coverage</th>
<th>$50,000.00</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional On-Route Loss of Life</td>
<td>NONE</td>
<td></td>
</tr>
<tr>
<td>Substitute Contractors</td>
<td>Covered On-Route</td>
<td></td>
</tr>
</tbody>
</table>

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)
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.

“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 ___________________________________________ Route No. ______

Name of Claimant (PLEASE PRINT) ________________________________

_________________________ ____________________________
First Middle Last

_________________________ ____________________________
Independent Contractor Substitute Independent Independent Contractor

Social Security No. ____________________________

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 ____________________________

Mother’s Name ____________________________

First Middle Last 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:

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 _____

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 From Month ______ Date ______ Year ______ At ______ o’clock ______ 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 ______ Date ______ Year ______ At ______ o’clock ______ M

CLAIMANT MUST ALSO COMPLETE PART TWO ON NEXT PAGE.  CL1 01/2008
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."

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.

Part Three

TO BE
COMPLETED
BY THE
NEWSPAPER

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)

<table>
<thead>
<tr>
<th>1. PATIENT’S NAME (First name, middle initial, last name)</th>
<th>2. PATIENT’S DATE OF BIRTH / /</th>
<th>3. INSURED’S NAME (First name, middle initial, last name)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. PATIENT’S ADDRESS (Street, city, state, ZIP code)</td>
<td>5. PATIENT’S SEX</td>
<td>6. INSURED’S ID No or MEDICARE No (include any letters)</td>
</tr>
<tr>
<td></td>
<td>MALE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FEMALE</td>
<td></td>
</tr>
<tr>
<td>7. PATIENT’S RELATIONSHIP TO INSURED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SELF</td>
<td>SPouse</td>
<td></td>
</tr>
<tr>
<td>CHILD</td>
<td>OTHER</td>
<td></td>
</tr>
</tbody>
</table>

| 9. OTHER HEALTH INSURANCE COVERAGE – Enter Name of Policyholder, Plan Name, Address and Policy or Medical Assistance Number |

<table>
<thead>
<tr>
<th>10. WAS CONDITION RELATED TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) PATIENT’S EMPLOYMENT YES NO</td>
</tr>
<tr>
<td>B) AN AUTO ACCIDENT YES NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE (Read back before signing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 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</td>
</tr>
<tr>
<td>SIGNED DATE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PHYSICIAN OR SUPPLIER INFORMATION</th>
</tr>
</thead>
</table>

| 13. I Authorize Payment of Medical Benefits to Undersigned Physician or Supplier for service described below |
| SIGNED (Insured or Authorized Person) |

| 14. DATE OF ILLNESS (FIRST SYMPTOM) 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 |
| 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 |

| 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. |

<table>
<thead>
<tr>
<th>24. A DATE OF SERVICE</th>
<th>B PLACE OF SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN</td>
<td></td>
</tr>
<tr>
<td>PROCEDURE CODE (IDENTIFY)</td>
<td></td>
</tr>
<tr>
<td>(Explain unusual services or circumstances)</td>
<td></td>
</tr>
<tr>
<td>D DIAGNOSIS CODE</td>
<td></td>
</tr>
<tr>
<td>E CHARGES</td>
<td></td>
</tr>
<tr>
<td>F CHARGES</td>
<td></td>
</tr>
</tbody>
</table>

| 25. SIGNATURE OF PHYSICIAN OR SUPPLIER (Read back before signing) |
| SIGNED DATE |

| 26. YOUR SOCIAL SECURITY NO. |
| 30. PHYSICIAN’S OR SUPPLIER’S NAME, ADDRESS, ZIP CODE & TELEPHONE NO. |

| 32. YOUR PATIENT’S ACCOUNT NO. |
| 33. YOUR EMPLOYER I D NO. |

| 27. TOTAL CHARGE |
| 28 AMOUNT PAID |
| 29 BALANCE DUE |

*PLACE OF SERVICE CODES*

<table>
<thead>
<tr>
<th>1-(H)-INPATIENT HOSPITAL</th>
<th>4-(H)-PATIENT’S HOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-(O)-OUTPATIENT HOSPITAL</td>
<td>5-DAY CARE FACILITY (PSY)</td>
</tr>
<tr>
<td>3-(O)-DOCTOR’S OFFICE</td>
<td>6-NIGHT CARE FACILITY (PSY)</td>
</tr>
<tr>
<td>7-(N)-NURSING HOME</td>
<td>8-(SN)-SKILLED NURSING FACILITY</td>
</tr>
<tr>
<td>9-AMBULANCE</td>
<td>A-(IL)-INDEPENDENT LABORATORY</td>
</tr>
<tr>
<td></td>
<td>B-OTHER MEDICAL/SURGICAL FACILITY</td>
</tr>
</tbody>
</table>

*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________________________

I. 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________________________
CLAIM BLANK

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

“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.”

<table>
<thead>
<tr>
<th>Part One CLAIMANT’S STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Newspaper</td>
</tr>
<tr>
<td>Route No.</td>
</tr>
<tr>
<td>Name of Claimant (PLEASE PRINT)</td>
</tr>
<tr>
<td>First</td>
</tr>
<tr>
<td>Independent Contractor</td>
</tr>
<tr>
<td>Social Security No.</td>
</tr>
<tr>
<td>Street Address</td>
</tr>
<tr>
<td>City &amp; State</td>
</tr>
<tr>
<td>Zip</td>
</tr>
<tr>
<td>Phone No.</td>
</tr>
<tr>
<td>Date of Birth</td>
</tr>
<tr>
<td>Date of Accident (MM/DD/YY)</td>
</tr>
<tr>
<td>Time</td>
</tr>
<tr>
<td>Where did Accident happen?</td>
</tr>
<tr>
<td>How did accident happen?</td>
</tr>
<tr>
<td>If automobile accident, attach copy of police report.</td>
</tr>
<tr>
<td>What injury did you receive?</td>
</tr>
<tr>
<td>If youth, do either of your parents work?</td>
</tr>
<tr>
<td>If adult, do you have other work?</td>
</tr>
<tr>
<td>If youth, Father’s Name</td>
</tr>
<tr>
<td>Mother’s Name</td>
</tr>
<tr>
<td>FATHER’S EMPLOYER/YOUR EMPLOYER</td>
</tr>
<tr>
<td>PHONE NO.</td>
</tr>
<tr>
<td>MOTHER’S EMPLOYER</td>
</tr>
<tr>
<td>PHONE NO.</td>
</tr>
<tr>
<td>Have you received or are you eligible to receive benefits from any of the following:</td>
</tr>
<tr>
<td>Yes ☑ No ☐ Auto Insurance</td>
</tr>
<tr>
<td>Yes ☑ No ☐ School Insurance</td>
</tr>
<tr>
<td>Yes ☑ No ☐ Individual Group Insurance BC/BS Camp Hill, PA 11-111</td>
</tr>
<tr>
<td>Yes ☑ No ☐ State or Federal Aid</td>
</tr>
<tr>
<td>Yes ☑ No ☐ Any other source of insurance</td>
</tr>
<tr>
<td>List names, addresses and treatment dates of all Doctors consulted for this injury:</td>
</tr>
<tr>
<td>Doctor’s Name</td>
</tr>
<tr>
<td>Robert Little, MD</td>
</tr>
<tr>
<td>List ALL Dates of Treatment At Doctor’s Office</td>
</tr>
<tr>
<td>Treatment At Hospital</td>
</tr>
<tr>
<td>Were you treated at the hospital for this injury?</td>
</tr>
<tr>
<td>Name of Hospital</td>
</tr>
<tr>
<td>If Yes Address of Hospital</td>
</tr>
<tr>
<td>Date Admitted</td>
</tr>
<tr>
<td>Date Discharged</td>
</tr>
<tr>
<td>Did you lose time from your newspaper route?</td>
</tr>
<tr>
<td>If yes, attach physician orders</td>
</tr>
<tr>
<td>If From Month</td>
</tr>
<tr>
<td>Date</td>
</tr>
<tr>
<td>Year</td>
</tr>
<tr>
<td>At</td>
</tr>
<tr>
<td>Yes To Month</td>
</tr>
<tr>
<td>Date</td>
</tr>
<tr>
<td>Year</td>
</tr>
<tr>
<td>At</td>
</tr>
<tr>
<td>o’clock</td>
</tr>
<tr>
<td>If you did not return to your newspaper route, when did you resume other activities?</td>
</tr>
<tr>
<td>CLAIMANT MUST ALSO COMPLETE PART TWO ON NEXT PAGE.</td>
</tr>
</tbody>
</table>
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.

[Signature]

January 31, 2002

Jane Doe

SIGNATURE OF INDEPENDENT CONTRACTOR/CLAIMANT

Jane Doe

SIGNATURE OF PARENT (if independent contractor is a minor)

[Signature]

“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 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

1. PATIENT’S NAME (First name, middle initial, last name) Jane Doe
2. PATIENT’S DATE OF BIRTH 01/15/1950
3. INSURED’S NAME (First name, middle initial, last name) Jane Doe

4. PATIENT’S ADDRESS (Street, City, State, ZIP code)
   2309 Market St.
   Camp Hill, PA 11-1111

5. PATIENT’S SEX MALE X FEMALE

6. OTHER HEALTH INSURANCE COVERAGE – Enter Name of Policyholder, Plan Name, Address and Policy or Medical Assistance Number
   BC/BS Camp Hill, PA 11-1111

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. PATIENT’S ADDRESS (Street, City, State, ZIP code)
   2309 Market St.
   Camp Hill, PA 11-1111

10. WAS CONDITION RELATED TO
    A) PATIENT’S EMPLOYMENT YES X NO
    B) AN AUTO ACCIDENT YES NO

11. 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

12. PHYSICIAN OR SUPPLIER INFORMATION
    14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY ACCIDENT OR PREGNANCY (LMP) 01/19/02
    15. DATE FIRST CONSULTED YOU FOR THIS CONDITION 01/19/02
    16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES X NO

    17. DATE PATIENT ABLE TO RETURN TO WORK UNDETERMINED
    18. DATES OF TOTAL DISABILITY FROM 1/21/02 THROUGH APPROXIMATELY 6 WKS
    19. NAME OF REFERRING PHYSICIAN Robert Little, MD
    20. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)
        ER. Phys Holy Spirit Hospital
    21. NAME OF REFERRING PHYSICIAN
        Robert Little, MD
    22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES NO

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

24. A DATE OF SERVICE 1/19/02
    B PLACE OF SERVICE O
    C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN
    D DIAGNOSIS CODE
    E CHARGE
    F

    PROCEDURE CODE (IDENTIFY)
    (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)

    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

26. TOTAL CHARGE
    AMOUNT PAID
    Balance DUE

27. TOTAL CHARGE
    AMOUNT PAID
    BALANCE DUE

28. MEDICARE

29. MEDICAID

30. CHAMPUS

31. OTHER

*PLACE OF SERVICE CODES
1-(H)-INPATIENT HOSPITAL
2-(O)-OUTPATIENT HOSPITAL
3-(O)-DOCTOR’S OFFICE
4-(H)-PATIENT’S HOME
5-(DAY CARE FACILITY (PSY)
6-NIGHT CARE FACILITY (PSY)
7-(H)-NURSING HOME
8-(SNF)-SKILLED NURSING FACILITY
9-AMBULANCE

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 A.M to 6:00 o’clock A.M

E. At what location does Independent Contractor receive papers? At Distribution Center

F. When did this accident happen? Date: January 18, 2002
At 5:30 o’clock A.M

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, M.D.

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.

Signed: John Miller, Circulation Director
Circulation Director or Manager

Name of Newspaper: HARRISBURG PATRIOT NEWS

NOTE: Do not sign this Letter of Recommendation if it was not an “ON ROUTE” accident.
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.
Save Money on ALL Prescription Drugs with Wilson Gregory

Includes all prescription drugs
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.

Significant savings
On average, you’ll save 15% or more off the cash price for Brand drugs and 40% or more off Generic drugs.

Use at almost any pharmacy
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.

Everybody, every time
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
Member ID: WGA1211
Group ID: WGA01
Valid for entire family

Our Mission
The mission of Wilson Gregory Discount Drug Plan is to provide relief to the many citizens who have little or no coverage for prescription medications. No one should have to pay full price for vital and sometimes life-saving drugs.

The Pharmacy Web Tools: Open 24/7
At www.mydiscountdrugcard.com you can:
- Locate participating pharmacies anywhere in the country
- 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
- Kroger
- Target
- Costco
- Giant
- Wal-Mart
- CVS
- Rite Aid
- Walgreens
- Eckerd
- Safeway
- Winn-Dixie
- K-mart
- Weis

associations
- Access Health
- United Drugs
- Leader

independents
Wilson Gregory Discount Drug Plan is also accepted by most independent pharmacies nationwide.

www.mydiscountdrugcard.com

THIS IS NOT INSURANCE - DISCOUNTS ONLY
By using this card the holder agrees to the terms under which it was issued. Void where prohibited. Process all prescriptions electronically.
Member Services: 1-800-974-3454
Pharmacy Help Desk: 1-800-481-0605