

**-PLEASE READ INSTRUCTIONS
ON REVERSE SIDE
BEFORE COMPLETING-**

**SEND ALL FORMS TO
CLAIMS ADMINISTRATOR:
BOLLINGER INC.
P.O. Box 706
Short Hills, NJ 07078-0706**

1. School District or Diocese:		2. School Within District or Parish Child Attends:		3. Master Policy No.:	
4. Claimant's Last Name:		First Name:		5. Date of Birth:	6. <input type="checkbox"/> Male <input type="checkbox"/> Female
7. Telephone:			8. Home Address:		
9. City/State/Zip Code:					

10. **Check activity in which student was involved when injured:**

A. Interscholastic Sports _____ Name of Sport _____

B. Cheerleading Twirling or Flagwaving Band Member

OR:

01 Physical Ed. Class 04 To and From School 07 Extra Curr. Activity ON Premises

02 Classroom or Hallway 05 Group Travel 08 Extra Curr. Activity OFF Premises

03 Playground (NOT Phys. Ed.) 06 Non-School Activity (24 Hr. Plan) 09 Spectator

Was School in Session? YES NO **Starting Time** _____ **Dismissal Time** _____

Is this the first claim form completed for this accident? Yes No

11. Date of Accident:	12. Time: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	13. How Did Accident Occur?
14. Where Did Accident Occur?		15. Part of Body Injured:

16. I certify that the activity checked above is school sponsored and supervised and is covered under a policy applied for and purchased by the policyholder.

Signature of School Official _____ Title _____ Date _____

AUTHORIZATIONS

17. MEDICAL AUTHORIZATION: I authorize the release of any medical or other information necessary to process this claim, including all data covering this and/or previous confinements and/or disabilities.	18. PAYMENT AUTHORIZATION: I authorize payment of medical benefits directly to the providers rendering services.
SIGNED _____ DATE _____	SIGNED _____ DATE _____

STATEMENT OF OTHER INSURANCE - MUST BE COMPLETED

1. Father's Name:	2. Name and Address of His Employer:
3. Mother's Name:	4. Name and Address of Her Employer:
5. <input type="checkbox"/> No, we do not have any personal or group medical insurance. I have enclosed a letter from my employer verifying this.	
6. <input type="checkbox"/> Yes, we do have other insurance. (Please complete #7).	
7. Names of other Insurance Companies	Address
8. <input type="checkbox"/> We have no other insurance. We are (please check one): <input type="checkbox"/> Self-employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled	

I hereby certify, swear and affirm that the information given above is true and accurate. I fully understand that any willful misrepresentation made by me in an attempt to collect benefits under this policy constitutes fraud and is punishable by law.

Parent or Guardian's Signature: _____ **Date** _____

PARENTS' INSTRUCTIONS FOR FILING A CLAIM:

The Accident Insurance coverage purchased by the Board of Education/School provides coverage on an **EXCESS BASIS** only. This means that only those medical expenses, which are **NOT** payable by your own personal or group insurance, are eligible for coverage under this policy up to the limits. Please follow these instructions below when filing a claim:

1. **THIS CLAIM FORM MUST BE MAILED TO BOLLINGER WITHIN 90 DAYS OF THE DATE OF ACCIDENT.**

Please be sure that:

- a) The school official has completed his/her section of the claim form.
 - b) You have completed and signed the Parent's Statement and Medical Authorization.
 - c) The Statement of Other Insurance section must be fully completed. If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.
2. IMMEDIATELY submit a claim for all medical expenses to the company that administers your personal or group insurance (including Major Medical coverage). **If you have coverage through an HMO or similar facility, you must use this facility first or your claim will not be covered under this policy.**
3. After your primary insurance has paid the medical expenses up to the policy limits, submit Itemized Bills **AND** copies of the Explanation of Benefits from your primary insurance company as you receive them and mail to the address shown below. **We cannot accept balance due bills.**
4. Please write the claimant's name, policy number, and date of accident on all Bills and Explanation of Benefits.
5. Please keep a copy of this Claim Form, all bills, and primary insurance Explanation of Benefits for your own records.
6. If you need further information, call 866-267-0092. DO NOT CALL THE SCHOOL.

Thank you for your cooperation.

PLAN ADMINISTRATION AND CLAIM SERVICE BY:



P.O. BOX 706, SHORT HILLS, N.J. 07078-0706 • TELEPHONE 866-267-0092