2019-20
Student Accident Claim Form
Please Read Instructions On The Next Page Before Completing

SEND ALL FORMS TO CLAIMS ADMINISTRATOR:
BOLLINGER INC.
P.O. Box 1346
Morristown, NJ 07962

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. ☐ Male ☐ Female	7. Telephone:

8. Home Address:	9. City/State/Zip Code:

10. Personal Email Address of Parent or Guardian:

11. **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
02 ☐ Classroom or Hallway
03 ☐ Playground (NOT Phys. Ed.)
04 ☐ To and From School
05 ☐ Group Travel
06 ☐ Non-School Activity (24 Hr. Plan)
07 ☐ Extra Curr. Activity ON Premises
08 ☐ Extra Curr. Activity OFF Premises
09 ☐ Spectator

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

12. Date of Accident:	13. Time: ☐ A.M. ☐ P.M.	14. How Did Accident Occur?

15. Where Did Accident Occur?	16. Part of Body Injured:

17. 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 _____

Email Address_____ Phone Number _____

AUTHORIZATIONS AND STATEMENT OF OTHER INSURANCE MUST BE COMPLETED BY PARENT OR GUARDIAN

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.

SIGNED _____ DATE _____

PAYMENT AUTHORIZATION: I authorize payment of medical benefits directly to the providers rendering services.

SIGNED _____ DATE _____

1. Father's Name:	2. Name and Address of His Employer:
3. Mother's Name:	4. Name and Address of Her Employer:

5. ☐ No, we do not have any personal or group medical insurance. I have enclosed a letter from my employer verifying this.
☐ We have no other insurance. We are (please check one): ☐ Self-employed ☐ Unemployed ☐ Disabled
☐ Yes, we do have other insurance. (Please complete #6).
☐ **We have a government funded plan (Medicaid, Tricare, etc.).** If you have Medicaid, please supply us with a copy of your card.

6. **Names of other Insurance Companies**	**Address**

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: PLEASE READ ALL INSTRUCTIONS BEFORE 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 TO ESTABLISH YOUR CHILD'S CLAIM FILE.**
   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.
2. Once you have sent this claim form to Bollinger, submit a claim for all medical expenses to the company that administers your personal or group insurance (including Major Medical coverage).
3. After your primary insurance has paid the medical expenses, up to the policy limits, submit all Bills (CMS-1500 from physicians and UB-04 from hospitals) with the corresponding Explanation of Benefits from your primary insurance company as you receive them and mail to the PO Box shown below. If you have paid any bills, you must include a receipt(s) or payment will be sent to the provider rendering the services.

   If this is a dental injury, your provider should submit injury related services only on an ADA Dental Form J430 or its equivalent and copies of corresponding Explanation of Benefits from your primary insurance company. Documents should be mailed to the PO Box shown below.

   We cannot accept balance due bills, statements, invoices or ledgers.
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 or have any questions, please call 866-267-0092 to speak to one of our highly qualified Customer Service Representatives between the hours of 8 a.m. and 5 p.m. E.S.T. Monday - Friday or contact us on our website www.BollingerSchools.com
   PLEASE DO NOT CALL THE SCHOOL.
7. After you have submitted your completed claim form and have received your first Explanation of Benefits from Bollinger Specialty Group, you will now have a claim number and you may go to www.BollingerSchools.com to enroll and check the status of your claim online.

PLAN ADMINISTRATION AND CLAIM SERVICE BY:

Bollinger Specialty Group
A Gallagher Company

P.O. BOX 1346, MORRISTOWN, N.J. 07962
TELEPHONE 866-267-0092

www.BollingerSchools.com

Fraud Warnings Disclosure

Any person who knowingly and with intent to defraud any insurance company or another 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 may subject the person to criminal and civil penalties. (Not applicable in AL, AR, CO, DC, FL, KS, KY, LA, MD, ME, NJ, NM, NY, OH, OK, OR, PA, PR, RI, TN, TX, VA, VT, WA, and WV.)

In **Arkansas, Louisiana, Rhode Island, or West Virginia**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

In **Alabama**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

In **Colorado**: 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.

In **District of Columbia**: 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.

In **Florida**: 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.

In **Kansas**: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to an insurer, purported insurer, or to or by a broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act and may be subject to criminal and/or civil fines or penalties.

In **Kentucky**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

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

In **Maryland**: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

In **New Jersey**: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

In **New Mexico**: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

In **New York**: 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.

In **Ohio**: Any person who, with 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 is guilty of insurance fraud.

In **Oklahoma**: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

In **Oregon**: Any person who knowingly and with intent to defraud any insurer or other person files an application for insurance or statement of claim containing any materially false information upon which an insurer relies, if such information was either material to the risk assumed by the insurer or the misinformation was provided fraudulently, may commit a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

In **Pennsylvania**: 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 subjects such person to criminal and civil penalties.

In **Puerto Rico**: Any person who has committed fraud, as defined in the law, shall incur a felony, and if convicted, shall be sanctioned for each violation by a penalty of a fine of not less than five thousand dollars ($5,000), nor more than ten thousand dollars ($10,000), or a penalty of imprisonment for a fixed term of three (3) years, or both penalties. If there were aggravating circumstances, the fixed penalty thus established may be increased up to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years. In addition to the penalties provided in this chapter, any person who, as a result of the fraud thus committed is benefited in any way to obtain insurance, or in the payment of a loss pursuant to an insurance contract, shall be imposed the payment of restitution of the amount of money resulting from the fraud. Every violation shall have a prescription term of (5) five years.

In **Texas**: 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.

In **Vermont**: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

2019-20
Formulario de Accidente del Estudiante
Lea las instrucciones en la página siguiente antes de completar

POR FAVOR MANDE LOS FORMULARIOS A:
CLAIMS ADMINISTRATOR
BOLLINGER INC.
P.O. Box 1346
Morristown, NJ 07962

1. Distrito Escolar	2. Escuela que Asiste el Niño/la Niña en el Distrito:	3. Master Policy No.:

4. Apellido del Reclamador:	Primer Nombre:	5. Fecha de nacimiento	6. ☐ Masculino ☐ Femenino	7.Telefono

8. Dirección:	9. Ciudad / Estado / Zona Postal:

10. Dirección de correo electrónico personal del padre o tutor:

11. **Marque actividad en cual participaba el estudiante cuando tuvo el accidente:**

A. ☐ Deportes Intrescolasticos _____
Nombre del Deporte

B. ☐ Animadoras ☐ Batutera o Banderetera ☐ Banda de Musica

O:

01 ☐ Clase de Educación Fisica
02 ☐ En la Clase o en el Pasillo
03 ☐ En el Patio de Recreo (pero NO durante clase de Educación Fisica
04 ☐ Yendo y Viniendo a/de la Escuela
05 ☐ Viajando en Grupo
06 ☐ Actividad Fuere de la Escuela (Plan de 24 horas)
07 ☐ Actividad Extra-Curricular (Despues de Escuela) Dentro de la Escuela
08 ☐ Actividad Extra-Curricular FUERA de la Escuela
09 ☐ Espectator

¿La Escuela estaba en sesion? ☐ **Si** ☐ **No** **Hora de Entrada:** _____ **Hora de Salida:** _____

12. Fecha del Accidente:	13. Hora: ☐ A.M. ☐ P.M.	14. ¿Cómo ocurrio el accidente?

15. ¿Donde ocurrió el accidente?	16. Parte del cuerpo herida/o:

17. Certifico que la actividad indicada arriba es patrocinda y supervisada por la escuela y que se cubre bajo una poliza que solicito y compro el dueño de dicha poliza.

Firma de Administrador (a) Escolar _____ Título: _____ Fecha _____

Dirección de correo electrónico _____ Número de teléfono _____

AUTORIZACION Y PRUEBA DE OTRO SEGURO, TIENE QUE COMPLETARLO LOS PADRES O EL GUARDIAN

AUTORIZACIONES MEDICA: Autorizo entrega de cualiquier informe medico tipo que sea necesario para procesar esta reclamacion, inclusivo de todos los datos pertinentes a esta limitación o otra incapacidad preva.	AUTORIZACIÓN DE PAGO: Autorizo pagar beneficios medicos directamente a los proveedores que prestaron servicios..
FIRMA _____ FECHA _____	FIRMA _____ FECHA _____

1. Nombre del Padre:	2. Nombre y Dirección de su Empleo:
3. Nombre de la Madre:	4. Nombre y Dirección de su Empleo:

5. ☐ NO tengo/tenemos seguro personal o de grupo de ningun tipo. La carta de mi empleo verificando que no tengo seguro medico esta uncluida.
☐ NO tengo/tenemos seguro medico soy/somos: ☐ Empleo Propio ☐ Desempleado ☐ Invalido
☐ SI, tengo/tenemos seguro personal o de grupo (Por favor complete #6).
☐ **Tenemos un plan financiado por el gobierno. (Medicaid, Tricare, etc.).** Si usted tiene seguro de enfermedad, por favor suplirnos con una copia de su tarjeta.

6. **Nombre de Otra(s) Compañia(s) de Seguro**	**Dirección**

Certifico, juro y afirmo que los informes dados aqui son verdaderos y correctos. Entiendo por completo que cualquier representación fradulenta hecha por mi con intenciones de recibir beneficios baja esta poliza constituye un fraude y puede ser castigable bajo la ley.

Firma de Madre/Padre/Guardian: _____ **Fecha** _____

PADRES: POR FAVOR, LEA TODAS LAS INSTRUCCIONES ANTES DE PRESENTAR UN RECLAMO:

La cobertura de seguro contra accidentes comprada por la Junta de Educación / Escuela proporciona cobertura únicamente en EXCESO. Esto significa que solo aquellos gastos médicos que NO sean pagaderos por su propio seguro personal o grupal son elegibles para cobertura bajo esta política hasta los límites.

Siga estas instrucciones a continuación cuando presente un reclamo:

1. **ESTE FORMULARIO DEBE SER ENVIADO POR CORREO A BOLLINGER DENTRO DE 90 DIAS DEL DIA DEL ACCIDENTE PARA ESTABLECER EL ARCHIVO DE RECLAMO DE SU HIJO.**
   Por favor verifique y hacer seguro que:

   a) El administrador escolar halla llenado su parte en le formulario de reclamacion.
   b) Usted halla llenado y firmado la declaracion y autorizacion medica de Padre/Madre.
   c) La Declaracion de Otra seccion de Seguro debe completarse por completo.

2. Una vez que usted haya mandado este formulario a Bollinger, presentar un reclamo por todos los gastos medicos a su compania que administra su seguro personal o grupo (incluyendo una cobertura medica importante).
3. Despues de que su seguro primario haya pagado sus gastos medicos, hasta los limites de poliza, enviar todas las facturas (CMS-1500 de los medicos y UB-04 de los hospitals) con la explicacion correspondiente de los Beneficios de su compania de seguros primaria a medida que los reciba y envie por correo a la PO BOX mostrado abajo.Si ha pagado alguna factura, debe incluir un recibo(s) o el pago se enviara al proveedor que presta el servicio.

   Si esto es una lesion dental, su proveedor debe presentar una lesion relacionada solamente en un formulario ADA Dental formulario J430 o su equivalente y copias de los correspondientes Explicacion de Beneficios de su compania de seguros primaria. Documentos deben ser enviados at PO BOX mostrado abajo.
   No podemos aceptar saldos adeudados, estados de cuenta, facturas o libros contables.

4. Por favor escriba el nombre del demandante, el numero de poliza y la fecha de accidente en todas las facturas y la Explicacion de Beneficios.

5. Por favor mantenga copia de ester formulario de reclamo, todas las facturas, y la Explicacion de Beneficios de su seguro primario para sus registros.

6. Si necesita mas informacion o tiene alguna pregunta, por favor llamar al 866-267-0092 para hablar con uno de nuestros altamante calificados Representantes de Servicio al Cliente entre las horas de 8 a.m. y 5 p.m. E.S.T. Lunes - Viernes o contactenos en nuestro sitio web www.BollingerSchools.com
   POR FAVOR NO LLAMAR A LA ESCUELA.

7. Despues de haber enviado su hoja de reclamo completa y haya recibido su primer Explicacion de Beneficios de parte de Bollinger Specialty Group, ahora tendra un numero de reclamo y pueden ir a www.BollingerSchools.com para inscribirse y verificar condicion de su reclamo en linea.

PLAN ADMINISTRACIÓN Y RECLAMO DE SERVICIO POR:

Bollinger Specialty Group
A Gallagher Company

P.O. BOX 1346, MORRISTOWN, N.J. 07962

TELEPHONE 866-267-0092

www.BollingerSchools.com

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