2019-20
Student - Volunteer 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

[] **CCD - PREP Activity**
[] **CYO Activity**
[] **CYO, CCD- PREP Volunteer**
[] **School Volunteer**

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** ____________

CLF-PA-100X-19

PARENTS: PLEASE READ ALL INSTRUCTIONS BEFORE FILING A CLAIM:

The Accident Insurance coverage purchased provides coverage on an **EXCESS** basis. Under this plan, the first $100 of covered charges are paid without regard to any other applicable coverage that may be in effect. After the first $100 in covered charges are paid, expenses which are **NOT** payable by your other 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) You have attached itemized bills to this form.
   d) The Statement of Other Insurance section must be fully completed.
2. If the claim totals more than $100, Bollinger will pay the first $100 and return the expenses to you for submision to your own personal insurance 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. The subsequent bills and Explanation of Benefits from your other insurance should be sent in as you receive them. Please write the claimant's name, policy number, and date of accident on all Bills and Explanation of Benefits.
   A new claim form is not necessary.
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.

FRAUD WARNING NOTICE

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.

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