-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. ☐ Male ☐ Female	7. Telephone:

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

10. E-mail address of Parent of 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 _____

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.
6. ☐ Yes, we do have other insurance. (Please complete #7).

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

8. ☐ We have no other insurance. We are (please check one): ☐ Self-employed ☐ Unemployed ☐ 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** _____

CLF-FX-13

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 organization), you must comply with their requirements 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 (CMS-1500 from physicians and UB-04 from hospitals) **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 or contact us on our website at www.BollingerSchools.com. DO NOT CALL THE SCHOOL.

   Thank you for your cooperation.

NETWORK PROVIDER

First Health Network

PLAN ADMINISTRATION AND CLAIM SERVICE BY:

Bollinger Insurance Solutions

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

www.BollingerSchools.com

FRAUD WARNING NOTICES

Your state may require the following notice: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, or misleading information is subject to criminal and civil penalties and may be guilty of a felony.

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.

Alaska, New Hampshire: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Maryland, New Mexico, Rhode Island, Texas, 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to any 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.

Delaware, Idaho, Indiana: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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.

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.

Kentucky, 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.

Maine, Tennessee, Virginia, 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 include imprisonment, fines and denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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 violation.

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.

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.

Oregon: 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 may be subject to prosecution for insurance fraud.