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 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

BOLLINGER, INC., A SUBSIDIARY OF
ARTHUR J. GALLAGHER & CO.

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

www.BollingerSchools.com

Student/Athletic Accident Insurance

Your school has purchased accident insurance coverage to protect all students involved in any school sponsored and supervised activities including sports against **accidental injury or death** occurring while the policy is in force. Coverage is provided by **Bollinger Specialty Group**. Usual & Customary benefits are provided on a full excess basis.

If your primary medical coverage is an HMO or similar plan, it is recommended that you follow their rules and guidelines for obtaining benefits. If the HMO or similar plan is not utilized, you could incur out of pockets expenses resulting from charges that are over the usual and customary benefit.

Following is an example of how a **Full Excess** claim is handled. A student incurs medical expenses of $100.00 for treatment of an injury sustained during recess. The student's parents have private group insurance. The medical bills must first be submitted to the parent's insurance, being the primary carrier. The primary insurance pays $65.00 of the bill and sends an explanation of benefits (EOB) to the parents. The parents then submit a copy of the original bills along with a claim form and the primary insurance EOB to **Bollinger Specialty Group,** who may then pay up to $35.00 (the amount of covered expense that is "in excess of medical expense paid by another plan providing medical benefits.")

Claims Instructions

In case of accident, notify the school immediately. You may obtain a claim form from the school or you may download one from www.BollingerSchools.com.

- The **claim form** must be submitted within **90 days** from the date of accident. ***If the claim form is not submitted in this time frame the claim may be denied.***
- Treatment must commence within **90 days** from the date of injury.
- Attach itemized bills (***CMS-1500 form for physicians & UB-04 forms for Hospitals***) showing treatment, dates of treatment, and charges. **Balance due bills will not be accepted.**
- Attach copies of the corresponding primary insurance's explanation of benefits (EOB).
- If there is no primary insurance through the parent or guardian's employer, a statement of verification from employer on their letterhead must also be submitted.
- Itemized bills and explanation of benefits must be submitted within **90 days** from the date of treatment.
- Forward additional bills and EOB's to: **Bollinger Specialty Group, P.O. Box 1346, Morristown, NJ 07962.**
- Please note the name of school district on all bills and correspondence. **NO ADDITIONAL CLAIM FORM IS NECESSARY.**
- It is the parent's responsibility to complete Part I of the claim form and submit the claim form to Bollinger Inc.
- Do **NOT** leave original claim form at the hospital or physician's office.
- You may provide **copy** of the claim form to the hospital or physician's office so they can bill Bollinger directly.
- If you have any questions, once your claim has been submitted and processed by Bollinger, please call the Bollinger the Claims Department toll free at **(866) 267-0092**.
- **You may also check the status of your claim via the Bollinger online portal. Please go to www.bollingerclaims.com and select "Check Claim Status" under the "Parent" section.**
- Any questions regarding claim reporting or issues with the processing of claims through Bollinger, contact Stephanie Brown, Claims Advocate at A.J. Gallagher, the School District's Insurance Agent, by phone toll free at (888) 232-9262, directly at (609) 430-4103, or by claims fax (609) 924-9221.

2018-19
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** _____

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.