-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. **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** _____

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

11. Date of Accident:	12. Time: ☐ A.M. ☐ 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. SIGNED _____ DATE _____	18. PAYMENT AUTHORIZATION: I authorize payment of medical benefits directly to the providers rendering services. 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. ☐ 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.

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