-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	04 ☐ To and From School	07 ☐ Extra Curr. Activity ON Premises
02 ☐ Classroom or Hallway	05 ☐ Group Travel	08 ☐ Extra Curr. Activity OFF Premises
03 ☐ Playground (NOT Phys. Ed.)	06 ☐ Non-School Activity (24 Hr. Plan)	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-PRX-11-500

PARENTS' INSTRUCTION FOR FILING A CLAIM:

The Accident Insurance coverage purchased by the Board of Education/School provides coverage on a **PRIMARY EXCESS BASIS.** This means that for those claims where the total of all medical expenses incurred exceeds $500 that those expenses which are **NOT** covered by your own personal or group insurance are eligible for coverage, up to the limits of the policy.

MAIL THIS CLAIM FORM TO BOLLINGER WITHIN 90 DAYS OF THE DATE OF THE ACCIDENT
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.
Please follow these instructions when filing a claim:

I. FOR CLAIMS TOTALING LESS THAN $500
   1. IMMEDIATELY submit Itemized Bills for all medical expenses to Bollinger, Inc.
      We cannot accept balance due bills.
   2. Please write claimant's name, policy number and date of accident on all bills.

II. FOR CLAIMS TOTALING $500 or MORE:
   1. The statement of other insurance section on the other side of this form must be fully completed. If either (or both) parent(s) is employed but have no insurance, please complete a statement of verification from the employer(s) on their letterhead.
   2. 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.**
   3. 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.**
   4. Please keep a copy of this claim form, all bills and primary insurance Explanation of Benefits for your own records.
   5. If you need further information call 866-267-0092 or you may contact us on our website at www.BollingerSchools.com. **DO NOT CALL THE SCHOOL.**

MAIL THIS CLAIM FORM TO BOLLINGER WITHIN 90 DAYS OF THE DATE OF THE ACCIDENT.

Please keep a copy of this Claim Form and all bills and primary insurance Explanations of Benefits for your records.

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

www.BollingerSchools.com