

# -PLEASE READ INSTRUCTIONS ON REVERSE SIDE 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. <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> A.M. <input type="checkbox"/> 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

<b>MEDICAL AUTHORIZATION:</b> 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 _____	<b>PAYMENT AUTHORIZATION:</b> I authorize payment of medical benefits directly to the providers rendering services.  SIGNED _____ DATE _____
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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** \_\_\_\_\_

## 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).
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](http://www.BollingerSchools.com). **DO NOT CALL THE SCHOOL.**

Thank you for your cooperation.

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](http://www.BollingerSchools.com)