

# -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. <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 <input type="checkbox"/> Physical Ed. Class         | 04 <input type="checkbox"/> To and From School                | 07 <input type="checkbox"/> Extra Curr. Activity ON Premises  |
| 02 <input type="checkbox"/> Classroom or Hallway       | 05 <input type="checkbox"/> Group Travel                      | 08 <input type="checkbox"/> Extra Curr. Activity OFF Premises |
| 03 <input type="checkbox"/> Playground (NOT Phys. Ed.) | 06 <input type="checkbox"/> Non-School Activity (24 Hr. Plan) | 09 <input type="checkbox"/> 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

<p><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.</p> <p>SIGNED _____ DATE _____</p>	<p><b>PAYMENT AUTHORIZATION:</b> I authorize payment of medical benefits directly to the providers rendering services.</p> <p>SIGNED _____ DATE _____</p>
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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). **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](http://www.BollingerSchools.com). **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

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