

-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 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 <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

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** _____

PARENT'S INSTRUCTIONS FOR FILING A CLAIM

1. This low cost policy has restrictions and limitations, and your claim may not be paid in full.
2. A School Official will complete and sign the front section of the claim form for school related injuries only.
3. If this accident is not a school related injury parent should complete the front of the claim form.
4. You must sign the Authorization at the bottom of the form.
5. Attach itemized bills to the claim form. **We can not accept balance due bills.**
6. **MAIL THIS CLAIM FORM TO BOLLINGER WITHIN 90 DAYS OF THE DATE OF THE ACCIDENT.**
7. Subsequent bills should be sent in as you receive them. Please show the student's name, the policy number, and the date of accident on all of these subsequent bills. An additional claim form is not necessary.
8. If you need further information call 866-267-0092 or contact us on our website at:
www.BollingerSchools.com
9. Please keep a copy of this Claim Form, 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