HOW TO FILE A CLAIM:

1. Complete this form within 90 days.
2. Attach Itemized Bills and Primary Carrier Statements
3. Mail to: BMI Benefits, LLC, P.O. Box 511, Matawan, NJ 07747 800-445-3126 (P) 732-583-9610 (F)

ANY PERSON WHO KNOWINGLY AND/OR WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY OR OTHER PERSONS FILES A STATEMENT OF CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION, MAY BE GUILTY OF INSURANCE FRAUD AND SUBJECT TO CRIMINAL AND SUBSTANTIAL CIVIL PENALTIES.

This part must be completed and signed by an official of the policyholder or the claim cannot be processed

PART 1A: POLICYHOLDER

School/Organization | Policy# BASE: BAH30000590715 CAT: SB20CCP052576

School Mailing Address | City, State, Zip

Injured Person's Name | Birth date | Male ☐ Female ☐

Date of Injury | Time | Type of Sport | Part of body injured

How did injury occur?

Sport Designation: Intercollegiate ◯ Intramurals ◯ Practice ◯ Game ◯ Other ◯

At the time of the injury, was the injured involved in an activity sponsored and supervised by the policy holder? YES ◯ NO ◯

Name of Supervisor | Was he/she a witness to the accident? YES ◯ NO ◯

Signature of Supervisor/Official | Title | Date

PART 1 B: INJURED PERSON'S INFORMATION

THE INJURED PERSON'S SOCIAL SECURITY NUMBER MUST BE PROVIDED AS REQUIRED BY THE CENTER FOR MEDICARE SERVICES

Injured Person's Social Security Number

Injured Person's Home Address (Street, City, State, Zip)

Is the Injured Person Employed? YES ◯ NO ◯ If yes, please fill out Section A below.

Is the Injured Person Married? YES ◯ NO ◯ Spouse's Name

Is the Spouse Employed? YES ◯ NO ◯ If yes, please fill out Section B below.

Are you covered by any other insurance policy, either as a dependent, group, individual, automobile medical or liability YES ◯ NO ◯

If Yes: Name of Insurance Carrier ______ Policy #:

PARENT/GUARDIAN INFORMATION

Father/Guardian Name	Mother/Guardian Name
Address (Street, City, State, Zip)	Address (Street, City, State, Zip)
Home Phone	Home Phone
Is the Father Employed? YES ◯ NO ◯	Is the Mother Employed? YES ☐ NO ☐

SECTION A (INSURED/FATHER)		SECTION B (SPOUSE/MOTHER)	
Employer		Employer	
Address (Street, City, State, Zip)		Address (Street, City, State, Zip)	
Business Phone		Business Phone	
Insurance Company	Policy#	Insurance Company	Policy#

MEDICAL INFORMATION AUTHORIZATION ASSIGNMENT OF BENEFITS:

You are hereby authorized to furnish at the request of and to BMI Benefits, LLC or the underwriting companies with which it works, information which you may possess; including findings and treatment rendered, X-rays and copies of all hospital and medical records, all occasioned by professional services and hospital care rendered on my behalf. The foregoing authorization is granted with the understanding that any legal rights I may ordinarily have to claim communications between us as privileged are hereby expressly and voluntarily waived. A Photostat of this authorization shall be considered as effective and valid as the original, PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Claimant or Authorized Person's Signature | Date

BOB MCCLOSKEY INSURANCE/ BMI BENEFITS, L.L.C

Claim Filing Instructions

Bob McCloskey Insurance provides insurance benefits for all athletes/students for the treatment of bodily injury resulting from covered accidents as specified in your policy. Please refer to your school's brochure or master policy for actual coverage terms.

CLAIM FORM

(1) The claim form must be completed in full and signed by the appropriate school official. Please be sure to detail accident information, include part of the body injured, how the injury occurred and the particular sport. A separate claim form (Part1A) is required for each injury.

(2) Please have the student/parent complete Part 1B of our claim form in full (Parent/Insured Information). We recommend that medical history and parent insurance information forms be completed prior to any athletic participation. Please keep this information on file in your office. If your institution provides their own parent insurance information forms, please attach a completed copy to our claim form. If there is no evidence of other valid and collectible insurance, we must still receive the completed form to process the claim. If you do not have this information on file, Part 1B must be completed in full before any payment of benefits can be considered.

(3) If the student does not have contact with a parent, please indicate this in Part 1B. Students that are independent of their parents need to write a short letter indicating this information. The letter must be signed by the student and dated.

(4) Please have the student sign and date the portion of the claim form indicating "Medical information authorization/Assignment of benefits".

ITEMIZED BILLS

(1) Attach itemized copies of all applicable bills, including those bills under any deductible your plan may have. Also, include those bills paid partially or in full by other insurance. Bills showing only "Balance forward" or "Balance due" are not acceptable. Examples of itemized bills are HCFA 1500 Forms (physician billing) and UB 92 and UB 04 (hospital billing)

(2) An itemized bill indicates the provider of service's full name and mailing address, type of service, date of service, fee charged and diagnosis. We will request any missing information from the provider of services. To assure quick processing, please be sure that the bill and the insurance statements submitted are for the same item. You will receive a copy of any correspondence. Feel free to offer our toll free number to any provider who wished to contact us.

(3) When sending additional bills and other insurance statements, please identify your school's name and the name of the injured student/athlete.

OTHER INSURANCE INFORMATION

(1) Your institution has purchased an insurance plan that provides benefits in excess of those expenses not paid or payable by any other valid or collectible insurance. Without this provision, the cost of student/athletic insurance would be prohibitive.

(2) Along with the itemized bill, include a copy of the explanation of benefits statement from the other insurance carrier. If any or all benefits are denied by other insurance, we will need a copy of the denial showing the reason charges were denied. (Include front and back of explanation of benefits when necessary)

(3) In the event the student is not covered by any other collectible insurance thru the student's or their parent's place of employment, we will request a letter from the appropriate employers verifying that no other coverage exists. The student can, also, provide a letter on company letterhead from the necessary employers verifying coverage does not exist at the time the claim is submitted.

HMO/PPO BENEFITS

(1) If an injured athlete/student has these types of insurance plans, we recommend you refer them to their primary care physician or obtain authorization that will allow you to use a non-network provider whenever possible. If it is not possible to use the network and payment of benefits are denied, you must provide us with the written statement of denial.

BMI Benefits, LLC
PO Box 511
76 Main Street
Matawan, NJ 077447
Phone: 800-445-3126
Fax: 732-583-9610

Diocese of Paterson

Student Accident Claim Form Instruction Sheet

The Diocese of Paterson carries student accident insurance that is intended to cover costs not covered by your primary health insurance carrier. You are eligible to file a claim for accidents involving your child that occurred during a school –related activity. Coverage also extends to CCD students, CYO participants and Volunteer Workers. Please complete the attached form and include the requested documents when submitting your claim.

1. **Part 1 of claim form**: Please compete the claimant information, date and description of the injury. The school will complete all other fields in this section.

2. **Part 2 of claim form**: Please complete all requested information regarding the student and each parent along with the primary insurance policy information.

3. The claim form must be signed by the parent or guardian.

4. You must attach copies of your primary carrier's Explanation of Benefits (EOB) and all itemized medical bills (known as HCFA's, UB-04's or UB-92's). The medical bills should show the ICD-9 codes for services provided.

5. If you have already paid the medical service provider and wish to be reimbursed directly, please attach a paid receipt or statement that verifies the payment.

6. Submit the completed claim form, itemized bills and primary insurance Explanation of Benefits to the insurance company, BMI Benefits, LLC.

7. You may contact BMI Benefits at 1-800-445-3126 to discuss your claim. Please be aware that settlement of your claim may take several weeks to process. When contacting BMI Benefits, please have your claim form available to ensure prompt assistance.

8. Please feel free to contact the Diocese's insurance representative, Charlie Eisenbies, if you have any difficulties completing the form or processing the claim.
   Charlie Eisenbies, Senior Account Executive, Gallagher Koster.
   617-769-6458; fax: 617-769-6417 or Charlie_Eisenbies@ajg.com