Student Accident Claim Form

Please Read Instructions On Next Page Before Completing

SEND ALL FORMS TO
CLAIMS ADMINISTRATOR:
RPS Bollinger
P.O. Box 1346
Morristown, NJ 07962
or email to
BollingerSchoolClaims GBS

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. Personal Email 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	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.
We have no other insurance. We are (please check one): Self-employed   Unemployed   Disabled
Yes, we do have other insurance. (Please complete #).
We have government funded plan (Tricare, Medicaid etc.)   If you have Medicaid please supply us

Names of other Insurance Companies	Address

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-FX-

PARENTS: PLEASE READ ALL INSTRUCTIONS BEFORE FILING A CLAIM:

1. **THIS FORM SHOULD BE MAILED, E-MAILED OR FAXED TO RPS BOLLINGER WITHIN 90 DAYS OF THE DATE OF ACCIDENT TO ESTABLISH YOUR CHILD'S FILE.**

   MAIL TO CLAIMS ADMINISTRATOR: RPS Bollinger, PO Box 1346, Morristown, NJ 07962

   E-MAILTO: bollingerschoolclaims.gbs@ajg.com with your child's name in the subject line. FAX

   TO: 973-921-2876. Please make sure you include a cover page with the following: ATTENTION SCHOOL CLAIMS DEPARTMENT.

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, subject to the limitations and exclusions.

Please be sure that:

1. The school completes the top portion of this claim form, up to and including #17. A parent completes the bottom portion, signs and dates the form, then sends a copy to RPS Bollinger.

   Once you have sent this claim form to RPS Bollinger, have all bills submitted to your personal or group insurance (including Major Medical coverage).

2 After your health insurance has processed the medical expenses, have the providers submit itemized bills **(UB04 for a Hospital/Facility & CMS-1500 for all providers)** with the corresponding Explanation of Benefits from your primary insurance company. Please note, if you have paid providers, all forms and proof of payment may be submitted for reimbursement. **Please do not submit balance due statements, non-itemized invoices or ledgers.**

   If this is a **dental injury**, the dentist should submit injury related services only on **ADA Dental Form J430** and copies of corresponding Explanation of Benefits from your primary insurance.

3 After you have submitted your completed claim form and have received your first **Explanation of Benefits** from RPS Bollinger, you will now have a claim number and you may visit our website @ **www.bollingerschools.com** to enroll in our online portal to check the status of your child's claim.

PLEASE DO NOT CALL THE SCHOOL.

If you have any questions on the process, please call 866-267-0092 between the hours of 8 am and 4:15 pm E.S.T. Monday – Friday. If you are unavailable during our regular business hours, please feel free to leave a message and our Customer Service Team will contact you the next business day.

PLAN ADMINISTRATION AND CLAIM SERVICE BY:

RPS™ RISK PLACEMENT SERVICES

BOLLINGER SPECIALTY GROUP

P.O. BOX 1346, MORRISTOWN, N.J. 07962
TELEPHONE 866-267-0092
FAX 973-921-2876

www.BollingerSchools.com

2022-2023 Student Accident Insurance

Claims Filing Instructions

Cut out or Show Your Medical Provider

Student Accident
(Secondary/Excess Insurance)

Providers & Hospitals, please bill RPS Bollinger directly including the name of Patient, Name of District, Diocese or Independent School and Diagnosis on all bills.

This is not a contract of insurance. The terms and conditions of coverage are set forth in the Policy issued to the school / Policyholder. The Policy is subject to the laws of the state in which it was issued.

SEND ALL FORMS TO CLAIMS ADMINISTRATOR:

RPS Bollinger
PO Box 1346
Morristown, NJ 07962
or email to:

BollingerSchoolClaims.GBS@AJG.com

Questions: Please contact our Customer Service Department @ 1-866-267-0092

FREQUENTLY ASKED QUESTIONS

Q. What is the purpose of Secondary/Excess Accident Insurance?

A. The coverage is intended to help cover medical expenses related to a covered injury that results from your participation in school's activities. The policy pays **after** any other valid/collectible insurance that the student carries. It is designed to cover expenses left to the patient's responsibility on their primary insurance Explanation of Benefits (EOB), such as co-pays, deductibles, and coinsurance for eligible medical treatment, subject to policy limitations and exclusions.

Q. In addition to the Claim Form, what documents are needed in order for the Student Accident Insurance to process a claim?

A. The provider must submit the following documents to the Claims Administrator, RPS Bollinger:

1) Itemized Medical Bill – The provider will either bill the claims administrator with a CMS 1500 or UB04, and it will contain the following information:
   - Provider's Name and address
   - Tax ID Number
   - Date(s) of Service
   - Diagnostic Code(s) and Procedure Code(s)
   - The Fee for Each Procedure

2) Primary Explanation of Benefits (EOB) – This is a statement from your primary insurance company that outlines what charges will be covered or denied, and what will be left as patient responsibility (co-pay, coinsurance, deductible, etc.).

Fraud Warnings Disclosure

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or 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 may subject the person to criminal and civil penalties. (Not applicable in AL, AR, CO, DC, FL, KS, KY, LA, MD, ME, NJ, NM, NY, OH, OK, OR, PA, PR, RI, TN, TX, VA, VT, WA, and WV.)

In **Arkansas, Louisiana, Rhode Island, or West Virginia**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

In **Alabama**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

In **Colorado**: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

In **District of Columbia**: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

In **Florida**: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

In **Kansas**: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to an insurer, purported insurer, or to or by a broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act and may be subject to criminal and/or civil fines or penalties.

In **Kentucky**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

In Maine, Tennessee, Virginia, or Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

In **Maryland**: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

In **New Jersey**: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

In New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

In **New Mexico**: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

In **New York**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

In **Ohio**: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

In **Oklahoma**: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

In **Oregon**: Any person who knowingly and with intent to defraud any insurer or other person files an application for insurance or statement of claim containing any materially false information upon which an insurer relies, if such information was either material to the risk assumed by the insurer or the misinformation was provided fraudulently, may commit a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

In **Pennsylvania**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 subjects such person to criminal and civil penalties.

In **Puerto Rico**: Any person who has committed fraud, as defined in the law, shall incur a felony, and if convicted, shall be sanctioned for each violation by a penalty of a fine of not less than five thousand dollars ($5,000), nor more than ten thousand dollars ($10,000), or a penalty of imprisonment for a fixed term of three (3) years, or both penalties. If there were aggravating circumstances, the fixed penalty thus established may be increased up to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years. In addition to the penalties provided in this chapter, any person who, as a result of the fraud thus committed is benefited in any way to obtain insurance, or in the payment of a loss pursuant to an insurance contract, shall be imposed the payment of restitution of the amount of money resulting from the fraud. Every violation shall have a prescription term of (5) five years.

In **Texas**: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

In **Vermont**: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.