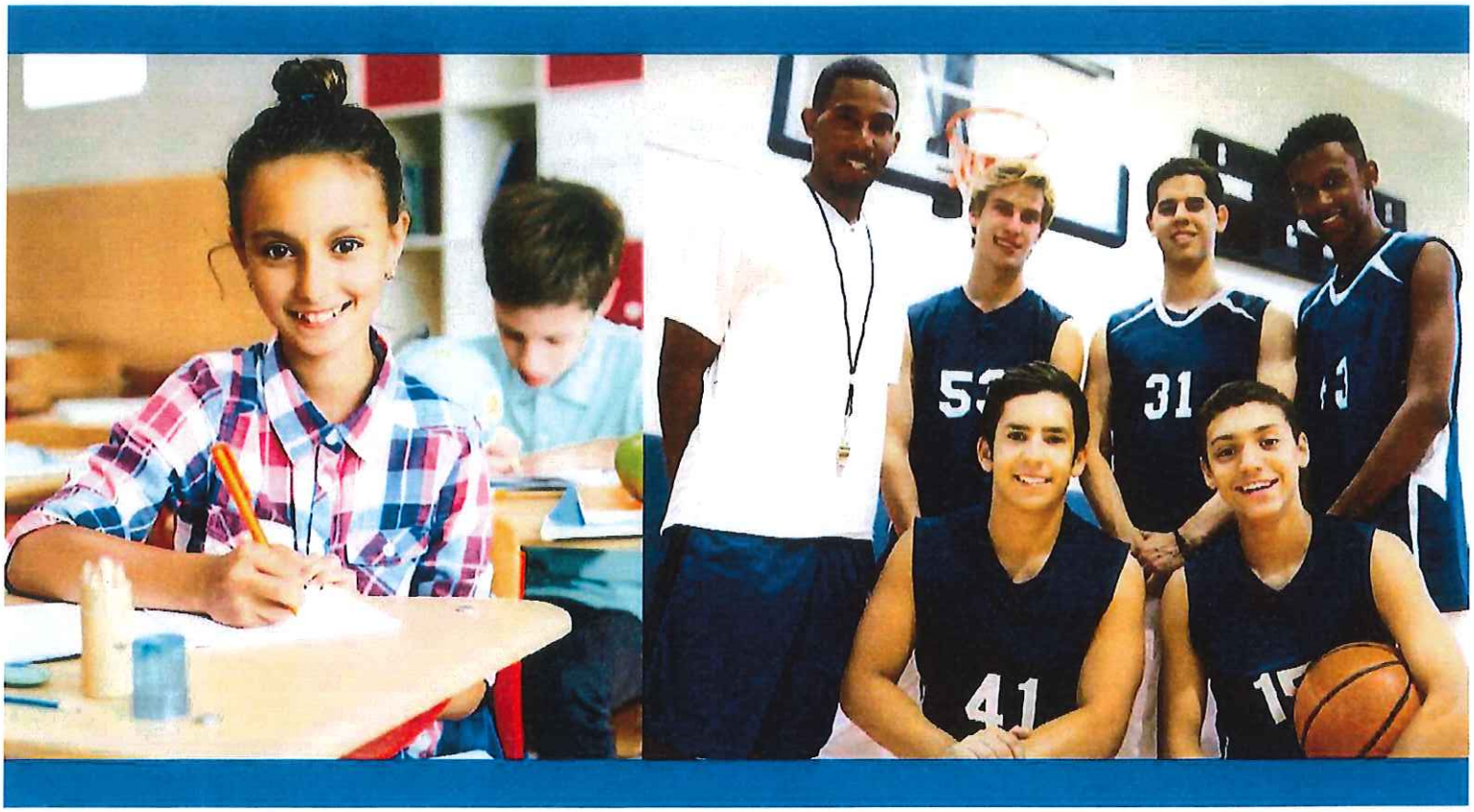
2019-20 New Jersey
STUDENT ACCIDENT INSURANCE PROGRAM
Multi-Benefit Protection



ACCIDENT INSURANCE PROTECTION HELPING PROVIDE:

For the Student - Sound coverage with a selection of plan options

For the Parent - Additional financial security to help in times of increasing medical costs

Administered by:

Bollinger Specialty Group
A Gallagher Company

Underwritten by:

GTL | GUARANTEE TRUST LIFE

Guarantee Trust Life Insurance Company (GTL)
1275 Milwaukee Ave., Glenview, IL 60025
www.gtlic.com

NJ-GTL-INCL-2019-20

2019-2020 Student Accident Insurance Plans

- Accidents happen! When they happen to your child, someone must pay the bills.
- Here are Accident only insurance plans to help cover your child either 24 hours a day (24-Hour Plan) or while in school (School-Time Plan).
- These plans provide benefits to help meet the cost of medical and Hospital expense.
- This is a Primary Plan. Covered Charges will be eligible for payment regardless of other insurance.
- Any benefits payable by the Policy as a result of medical, surgical, dental, Hospital or nursing service will be paid directly to the Hospital or person rendering such service unless proof of payment in full is provided.

24-HOUR	SCHOOL TIME	IMPORTANT PROTECTION FACTS
✓	✓	Becomes effective the date premium payment is received by Bollinger Specialty Group (but not prior to the opening day of school). Students participating in preschool practice or play for interscholastic sports sanctioned by the High School Athletic Association will be covered as of the date of actual premium payment but only while engaged in actual practice, off-season physical conditioning or game sessions. Other aspects of coverage will not start sooner than the first date of regular school session.
✓	✓	Provides coverage during the hours that school is in regular session.
✓		Provides 24-Hour-A-Day protection.
✓	✓	Provides coverage during the time necessary for travel between the insured's home and the beginning or end of regular school sessions.
✓	✓	Provides coverage while participating in (or attending) activities organized, sponsored and supervised by the school. Coverage is also provided for travel directly to and from such activities in a Designated Vehicle furnished by the school.
	✓	Coverage expires at the close of the regular school term. (Coverage will be extended while attending academic classes for credit in the summer, when classroom sessions are exclusively sponsored and solely supervised by the school; however, no coverage will be provided for travel to and from classes).
✓		Coverage continues without interruption all summer until school re-opens for the following term.

24-Hour-A-Day Accident Coverage

24-Hour-A-Day Protection for each Covered Accident

Helps protect your child for the entire school year and extends **throughout the summer** - right up to the day school opens.

Your child's coverage is good **WORLDWIDE, 24-HOURS-A-DAY**. This includes covered accidents:

✎ At home ✎ At play ✎ At school ✎ On vacation ✎ Scouting, camping etc. ✎ During covered travel

✎ While engaged in sports, except those specifically excluded

School-Time Accident Coverage

Helps protect your child while attending regular school sessions. Includes coverage for travel directly to and from your residence to attend regular school sessions for travel time required, but not more than one hour before or after regular classes. Travel time on the school bus is extended for any additional time needed. In addition, coverage is provided while participating in (or attending) covered activities exclusively organized, sponsored and solely supervised by the school and school employees, including travel directly to and from the activity in a Designated Vehicle furnished by the school and supervised solely by school employees.

Sports Accident Coverage

Interscholastic sports (except football), including practice and off-season physical conditioning, are covered by the 24-Hour-A-Day Accident Coverage and School-Time Accident Coverage. Travel is also covered when going directly and uninterruptedly to and from practice or competition when traveling as a group in a Designated Vehicle.

2019-2020 Student Accident Insurance Plans

What's Covered? *Up to* $25,000.00 as described under Coverage and Benefits *for:*

- ACCIDENTS OCCURRING WHILE COVERAGE IS IN FORCE
- LOSS FROM ACCIDENTAL BODILY INJURY RESULTING DIRECTLY AND INDEPENDENTLY OF ALL OTHER CAUSES
- COVERED MEDICAL EXPENSE WHICH BEGINS WITHIN 90 DAYS OF THE ACCIDENT AND IS INCURRED WITHIN 52 WEEKS OF THE ACCIDENT

Injury means bodily Injury due to an Accident which results directly and independently of disease, bodily infirmity, or any other causes; solely, directly and independently of all other causes, results in medical expense; occurs after the effective date of the Insured's coverage under the Policy; and occurs while the Policy is in force. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

BENEFITS ARE PAYABLE *UP TO* THE DOLLAR AMOUNTS SPECIFIED BELOW

COVERAGE AND BENEFITS	
R&C means Reasonable and Customary charges	
Maximum Benefit Amount Per Injury	$25,000.00
Deductible	$0.00
Hospital Room and Board and general nursing care	100% of R&C
Intensive Care	100% of R&C
Inpatient Hospital Miscellaneous Expense	100% of R&C
Doctor's fees for surgery	100% of R&C
Assistant Surgeon Expense	100% of R&C
Anesthesia Services	100% of R&C
Non-Surgical Inpatient and Outpatient Doctors' Visits	100% of R&C
Hospital Emergency Care	100% of R&C
Outpatient X-ray and Laboratory Services	100% of R&C
Outpatient Imaging procedures for MRI/CAT Scan	100% of R&C
Ambulance Expense	100% of R&C
Urgent Care Center Expense	100% of R&C
Durable Medical Equipment, including Orthopedic Appliances	100% of R&C
Prescription Drugs	100% of R&C
Physical Therapy, rendered by a Doctor or Hospital	100% of R&C
Dental Treatment for Injury to Sound, Natural Teeth	100% of R&C
Casts, Non-surgical	100% of R&C
Ambulatory Surgical Facility	100% of R&C
Replacement expense for broken eyeglasses, lenses, contact lenses, hearing aids resulting from an Injury requiring medical treatment	100% of R&C
Registered Nurse Expense	100% of R&C
Loss of Life	$10,000.00
Single Dismemberment	$10,000.00
Double Dismemberment	$20,000.00
PREMIUMS (ONE-TIME ANNUAL PAYMENT)	
SCHOOL-TIME ACCIDENT COVERAGE Grades Pre-K - 12 includes all activities and interscholastic sports, except football	$123.00
24-HOUR-A-DAY ACCIDENT COVERAGE Grades Pre-K - 12 includes all activities and interscholastic sports, except football	$212.00

2019-2020 Student Accident Insurance Plans

EXCLUSIONS

THE POLICY DOES NOT PROVIDE BENEFITS FOR: (1) Treatment, services or supplies which are not Medically Necessary; are not prescribed by a Doctor as necessary to treat an Injury; are Experimental/Investigational in nature; are received without charge or legal obligation to pay; are received from persons employed or retained by the Policyholder or any Family Member, unless otherwise specified; or are not specifically listed as Covered Charges in the Policy; (2) Intentionally self-inflicted Injury; (3) Injury by acts of war, whether declared or not; (4) Injury received while traveling or flying by air, except as a fare paying passenger on a regularly scheduled commercial airline; (5) Treatment of Mental or Nervous Disorders; (6) Suicide or attempted suicide; (7) Heart and/or circulatory malfunction resulting from participation in a Covered Activity, such as stroke, heat exhaustion (except as specifically stated), heart attack, and brain circulatory malfunctions; (8) Repetitive motion injuries, strains, hernia, tendinitis, bursitis, spondylolysis, osteochrondritis dissecans not related to a specific Injury; (9) Any penalty imposed by Other Valid and Collectible Insurance or Plan for failure to follow plan procedures; (10) Re-Injury or complications of an Injury which occurred prior to the Policy's Effective Date; (11) Dental treatment, except as specifically stated; (12) Injury sustained fighting or brawling, except as an innocent victim; (13) Injury sustained while committing or attempting to commit a felony; (14) Loss sustained or contracted as a consequence of being intoxicated or being under the influence of any narcotic unless administered or consumed on the advice of a Doctor; (15) Injury sustained scuba diving; (16) Any expense for which benefits are payable under a Catastrophic Accident Insurance Program of the State Interscholastic Activities Association; (17) Injury sustained while participating in or practicing for interscholastic tackle football, including travel, unless optional coverage has been purchased; (18) Injury which occurs while the Insured is on active duty service in any armed forces. Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days; (19) Injury sustained flying in an ultra-light, hang gliding, parachuting or bungee-cord jumping; (20) Cosmetic or plastic surgery, except for reconstructive surgery on an injured part of the body; (21) Treatment of illness, disease ,or infections, except pyogenic infections or bacterial infections which result from an accidental open cut or the accidential ingestion of contaminated substances.

To file a claim: Report accidents that happen during the school day to a school official. If you purchased 24-Hour-A-Day coverage and the accident occurs after school hours, the school is not required to sign the claim form.

Claim forms are available on our website: www.BollingerSchools.com

Group Blanket Accident insurance products are issued on Form Series GP-2020 or GP-1200 by Guarantee Trust Life Insurance Company, Glenview, IL. These products and their features are subject to state availability and may vary by state. Certain exclusions and limitations may apply. The exact provisions governing the insurance are contained in the Policy issued to the Policyholder and certain provisions may be administered to conform to state requirements. The Policy shall control in the event of any conflict between the Policy and this brochure. For complete details of coverage please contact the agent administering the program.

NO REFUNDS ARE AVAILABLE

ID CARD

STUDENT ACCIDENT INSURANCE

Name: _____

Street Address: _____

Town: _____ City: _____ State: ____ Zip: _____

School District: _____

To obtain a claim form, please visit www.BollingerSchools.com

Administered by:

Bollinger Specialty Group

P.O. Box 1346, Morristown, NJ 07962

1-866-267-0092

Please store your card in a safe location for future reference.

New Jersey: Enrollment for Student Accident Insurance

LAST NAME _____

FIRST NAME _____ MIDDLE INITIAL _____

☐ MALE ☐ FEMALE DATE OF BIRTH ____/____/____ (Month/Day/Year)

STREET ADDRESS _____

CITY OR TOWN _____ STATE _____ ZIP CODE _____

EMAIL ADDRESS _____

NAME OF PARENT OR GUARDIAN (BENEFICIARY) PLEASE PRINT _____

All statements made on this enrollment form are true and complete to the best of my knowledge and belief.
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NAME OF SCHOOL DISTRICT _____

SCHOOL NAME _____ GRADE

Please select the plan desired.

SCHOOL SPONSORED STUDENT ACCIDENT INSURANCE PLAN
Premium Cost Per Year

	A. SCHOOL TIME PLAN	B. 24-HOUR PLAN
Students Grades Pre-K-12	☐ $123.00	☐ $212.00

☐ I enclose $_____ Total Premium

PARENT'S SIGNATURE _____ TODAY'S DATE _____

NJ-GTL-INCL

Mail this form and the appropriate premium to: **Bollinger, Inc., PO Box 1515, Morristown, NJ 07962.** Your cancelled check is your receipt.

2019-20
Student Accident Claim Form
Please Read Instructions On The Next Page 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. ☐ 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
02 ☐ Classroom or Hallway
03 ☐ Playground (NOT Phys. Ed.)
04 ☐ To and From School
05 ☐ Group Travel
06 ☐ Non-School Activity (24 Hr. Plan)
07 ☐ Extra Curr. Activity ON Premises
08 ☐ Extra Curr. Activity OFF Premises
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 _____

Email Address_____ Phone Number _____

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.	PAYMENT AUTHORIZATION: I authorize payment of medical benefits directly to the providers rendering services.
SIGNED _____ DATE _____	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 #6).
☐ **We have a government funded plan (Medicaid, Tricare, etc.).** If you have Medicaid, please supply us with a copy of your card.

6. **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** _____

PARENTS: PLEASE READ ALL INSTRUCTIONS BEFORE FILING A CLAIM:

1. This low cost policy has restrictions and limitaions. Your claim may not be paid in full.

2. A School Official must 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 claim form.

4. You must sign the Medical Authorization portion of the form.

5. Attach itemized bills (CMS-1500 from physicians and UB-04 from hospitals) to the claim form and mail to the PO Box shown below. If you have paid any bills, you must include a receipt(s) or payment will be sent to the provider rendering the service.

   If this is a dental injury, submit an ADA Dental Form J430 or its equivalent for injury related services only along with the claim form and mail to the PO Box shown below.
   We cannot accept balance due bills, statements, invoices or ledgers.

6. **MAIL THIS CLAIM FORM TO BOLLINGER SPECIALTY GROUP WITHIN 90 DAYS OF THE DATE OF THE ACCIDENT.**

7. Subsequent bills should be mailed in as you receive them. Please show the student's name, policy number, and date of the accident on all correspondence. An additional claim form is not necessary.

8. Please keep a copy of this Claim Form and all bills for your own records.

9. If you need further information or have any questions, please call 866-267-0092 to speak to one of our highly qualified Customer Service Representatives between the hours of 8 a.m. and 5 p.m. E.S.T. Monday - Friday or contact us on our website www.BollingerSchools.com
   PLEASE DO NOT CALL THE SCHOOL.

10. After you have submitted your completed claim form and have received your first Explanation of Benefits from Bollinger Specialty Group, you will now have a claim number and you may go to www.BollingerSchools.com to enroll and check the status of your claim online.

PLAN ADMINISTRATION AND CLAIM SERVICE BY:

Bollinger Specialty Group
A Gallagher Company

P.O. BOX 1346, MORRISTOWN, N.J. 07962
TELEPHONE 866-267-0092

www.BollingerSchools.com

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 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.

Catlin Insurance Company, Inc.

Dental Accident Claim Form

Claimant's Statement

(Please print – Attach separate sheet if additional space required)

CLAIMANT'S STATEMENT

Claimant's Name_____ Date of Birth ___/___/___ Sex: □ M □ F

Claimant's Address _____
(Street) (City) (State) (Zip)

Parent/Guardian Name _____ Best Contact Phone No.: ( ) _____

Name/City/State of school _____

Policy Number _____

CLAIM INFORMATION

Date and Time of accident _____/_____/_____ _____ □ AM □ PM

Please describe the location (playground, gym, etc.) and circumstances of accident (attach separate sheet if needed):

_____

_____

_____

_____

Below information Must be completed by School Official

Printed Name of School/Camp Official:_____ Title:_____

School/Camp Official's Signature:_____ Phone #:_____

WE MUST RECEIVE EMERGENCY ROOM OR OTHER FIRST TREATMENT NOTE (URGENT CARE, DOCTOR'S OFFICE) AND ANY OTHER MEDICAL RECORDS TO DEMONSTRATE CARE AND TREATMENT OF ACCIDENT RELATED INJURIES.

FILING INSTRUCTIONS

- ▶THIS CLAIM FORM MUST BE RECEIVED WITHIN 90 DAYS OF THE DATE OF ACCIDENT.
- ▶THE RESPONSIBLE PARENT/GUARDIAN SHOULD COMPLETE THIS PAGE IN FULL.
- ▶THE ATTENDING DENTIST SHOULD COMPLETE THE ATTACHED DENTIST'S STATEMENT. THE DENTIST MAY SUBMIT THE FORM DIRECTLY TO OUR OFFICE, OR YOU MAY RETURN IT WITH THIS CLAIM FORM AND OTHER DOCUMENTS.
- ▶WE MUST RECEIVE ITEMIZED BILLS. WE CANNOT CONSIDER BALANCE DUE STATEMENTS WHICH ARE TYPICALLY NOT ITEMIZED. YOUR PROVIDER MAY FILE DIRECTLY ON YOUR BEHALF.
- ▶MAKE COPIES OF THE AUTHORIZATION TO RELEASE INFORMATION FORM BEFORE COMPLETING THE PROVIDER SECTION IF YOU PLAN TO HAVE DOCUMENTS FROM MORE THAN ONE PROVIDER SUBMITTED FOR CONSIDERATION OF THIS CLAIM. PLEASE CALL US IF YOU NEED ADDITIONAL FORMS. GIVE THE AUTHORIZATION FORM TO ANY PROVIDER WHOSE RECORDS YOU WOULD LIKE TO SUBMIT WITH YOUR CLAIM (IF APPLICABLE).*

RETURN ALL DOCUMENTS TO:
Administrative Concepts, Inc.
994 Old Eagle School Road, Suite 1005
Wayne, PA 19087

TOLL FREE CUSTOMER SERVICE (888) 293-9229
Fax: (610) 293-9299
Email: aciclaims@visit-aci.com

2019-20
Formulario de Accidente del Estudiante
Lea las instrucciones en la página siguiente antes de completar

POR FAVOR MANDE LOS FORMULARIOS A:
CLAIMS ADMINISTRATOR
BOLLINGER INC.
P.O. Box 1346
Morristown, NJ 07962

1. Distrito Escolar	2. Escuela que Asiste el Niño/la Niña en el Distrito:		3. Master Policy No.:	
4. Apellido del Reclamador: Primer Nombre:		5. Fecha de nacimiento	6. ☐ Masculino ☐ Femenino	7.Telefono
8. Dirección:	9. Ciudad / Estado / Zona Postal:			
10. Correo Electronico del Padre o Guardian:				

11. **Marque actividad en cual participaba el estudiante cuando tuvo el accidente:**

A. ☐ Deportes Intrescolasticos_____
Nombre del Deporte

B. ☐ Animadoras ☐ Batutera o Banderetera ☐ Banda de Musica

O:

01 ☐ Clase de Educación Fisica
02 ☐ En la Clase o en el Pasillo
03 ☐ En el Patio de Recreo (pero NO durante clase de Educación Fisica
04 ☐ Yendo y Viniendo a/de la Escuela
05 ☐ Viajando en Grupo
06 ☐ Actividad Fuere de la Escuela (Plan de 24 horas)
07 ☐ Actividad Extra-Curricular (Despues de Escuela) Dentro de la Escuela
08 ☐ Actividad Extra-Curricular FUERA de la Escuela
09 ☐ Espectator

¿La Escuela estaba en sesion? ☐ **Si** ☐ **No** **Hora de Entrada:** _____ **Hora de Salida:** _____

12. Fecha del Accidente:	13. Hora: ☐ A.M. ☐ P.M.	14. ¿Cómo ocurrio el accidente?
15. ¿Donde ocurrió el accidente?		16. Parte del cuerpo herida/o:

17. Certifico que la actividad indicada arriba es patrocinda y supervisada por la escuela y que se cubre bajo una poliza que solicito y compro el dueño de dicha poliza.

Firma de Administrador (a) Escolar _____ Título: _____ Fecha _____

Dirección de correo electrónico_____ Número de teléfono _____

AUTORIZACION Y PRUEBA DE OTRO SEGURO, TIENE QUE COMPLETARLO LOS PADRES O EL GUARDIAN

AUTORIZACIONES MEDICA: Autorizo entrega de cualquier informe medico tipo que sea necesario para procesar esta reclamacion, inclusivo de todos los datos pertinentes a esta limitación o otra incapacidad preva.	AUTORIZACIÓN DE PAGO: Autorizo pagar beneficios medicos directamente a los proveedores que prestaron servicios..
FIRMA _____ FECHA _____	FIRMA _____ FECHA _____

1. Nombre del Padre:	2. Nombre y Dirección de su Empleo:
3. Nombre de la Madre:	4. Nombre y Dirección de su Empleo:

5. ☐ NO tengo/tenemos seguro personal o de grupo de ningun tipo. La carta de mi empleo verificando que no tengo seguro medico esta uncluida.
☐ NO tengo/tenemos seguro medico soy/somos: ☐ Empleo Proplo Desempleado ☐ Invalido
☐ Si, tengo/tenemos seguro personal o de grupo (Por favor complete #6).
☐ **Tenemos un plan financiado por el gobierno. (Medicald, Tricare, etc.).** Si usted tiene seguro de enfermedad, por favor suplirnos con una copia de su tarjeta.

6. **Nombre de Otra(s) Compañia(s) de Seguro**	**Dirección**

Certifico, juro y afirmo que los informes dados aqui son verdaderos y correctos. Entiendo por completo que cualquier representación fradulenta hecha por mi con intenciones de recibir beneficios baja esta poliza constituye un fraude y puede ser castigable bajo la ley.

Firma de Madre/Padre/Guardian: _____ **Fecha** _____

PADRES: POR FAVOR, LEA TODAS LAS INSTRUCCIONES ANTES DE PRESENTAR UN RECLAMO:

1. Esta poliza de bajo costo que tiene restricciones y limitaciones, y su reclamo no puede ser pagado en su totalidad.
2. Un funcionario de la escuela completa y firmar la seccion delantera del formulario de solicitud para la escuela relacionadas con lesiones solamente.
3. Si este accidente no es una lesion relacionado con la escuela, los padres tienen que completar la parte delantera del formulario de reclamacion.
4. Debe firmar la parte Autorizacion medica del formulario.
5. Adjuntar facturas detalladas (CMS-1500 de los medicos y UB-04 de los hospitales) al formulario de reclamo y envielo por correo a la casilla de correo a continuacion. Si ha pagado alguna factura, debe incluir un recibo(s) o el pago se enviara al proveedor que presta el servicio.

   Si se trata de una lesion dental, envie un Formulario Dental ADA J430 o su equivalente para los servicios relacionados con lesiones solo junto con el formulario de reclamo y envielo por correo a la casilla de correo que se muestra a continuacion.

   No podemos aceptar saldos adeudados, estados de cuenta, facturas o libros contables.
6. **ENVÍE ESTE FORMULARIO DE RECLAMACIÓN AL GRUPO DE ESPECIALIDAD DE BOLLINGER EN EL PLAZO DE 90 DÍAS A PARTIR DE LA FECHA DEL ACCIDENTE.**
7. Las facturas posteriores deben enviarse por correo cuando las reciba. Por favor muestre el nombre del estudiante, política número y fecha del accidente en toda la correspondencia. Un formulario de reclamo adicional no es necesario.
8. Por favor mantenga copia de ester formulario de reclamo, todas las facturas, y la Explicacion de Beneficios de su seguro primario para sus registros.
9. Si necesita mas informacion o tiene alguna pregunta, por favor llamar al 866-267-0092 para hablar con uno de nuestros altamante calificados Representantes de Servicio al Cliente entre las horas de 8 a.m. y 5 p.m. E.S.T. Lunes - Viernes o contactenos en nuestro sitio web www.BollingerSchools.com

   POR FAVOR NO LLAMAR A LA ESCUELA.
10. Despues de haber enviado su hoja de reclamo completa y haya recibido su primer Explicacion de Beneficios de parte de Bollinger Specialty Group, ahora tendra un numero de reclamo y pueden ir a www.BollingerSchools.com para inscribirse y verificar condicion de su reclamo en linea.

PLAN ADMINISTRACIÓN Y RECLAMO DE SERVICIO POR:

Bollinger Specialty Group
A Gallagher Company

P.O. BOX 1346, MORRISTOWN, N.J. 07962

TELEFONE 866-267-0092

www.BollingerSchools.com

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 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.

ASSIGNMENT OF BENEFITS / CLAIMANT SIGNATURE

I certify that the information provided above is true and that the circumstances of the accident are as described herein. I acknowledge receipt of the attached Fraud Warnings Disclosure, and I understand that the submission of information for the purpose of defrauding an insurance company may be subject to criminal investigation and or penalties.

_____ _____

Signature of Parent/Guardian/Responsible Party **Date**

I assign payment of benefits directly to the service provider(s) associated with this loss and who provide standardized billing forms which include service itemization, coding, billing address and business tax identification number (TID) for tax purposes.

_____ _____

Signature of Parent/Guardian/Responsible Party **Date**

Catlin Insurance Company, Inc.

Dental Accident

ATTENDING DENTIST'S STATEMENT

DENTISTS PLEASE NOTE: THIS IS A LIMITED POLICY. YOU MAY NOT RECEIVE PAYMENT IN FULL FOR SERVICES RENDERED. BALANCES AFTER BENEFIT DISTRIBUTION ARE THE RESPONSIBILITY OF THE PATIENT.

IN ORDER TO BE PAID DIRECTLY, YOU MUST SUBMIT THIS QUESTIONAIRRE ALONG WITH STANDARDIZED BILLING FORMS WHICH CONTAIN ALL APPROPRIATE CODING, CHARGES, YOUR BILLING ADDRESS AND TAX IDENTIFICATION NUMBER.

PATIENT'S NAME:	REPORTED DATE OF INJURY:
DESCRIBE THE EXACT NATURE OF THE INJURY:	
DATE YOU FIRST TREATED THE PATIENT FOR THIS COMPLAINT:	_____ / _____ / _____
WERE THE EFFECTS OF THE INJURY IMMEDIATELY APPARENT? □ YES □ NO	IF NOT, WHEN DID THEY BECOME APPARENT?
HAVE YOU EVER TREATED THE PATIENT FOR A SIMILAR CONDITION? □ YES □ NO	IF YES, WHEN? PLEASE EXPLAIN:
HAS THE PATIENT FULLY RECOVERED FROM THIS SPECIFIC INJURY? □ YES □ NO	IF NOT, WHAT FURTHER TREATMENT DO YOU EXPECT TO PROVIDE?
IN YOUR PROFESSIONAL OPINION, WAS THIS CONDITION CAUSED SOLELY AND INDEPENDENTLY BY ACCIDENTAL INJURY? □ YES □ NO	IF NOT, PLEASE EXPLAIN ANY UNDERLYING MEDICAL CONDITION OR OTHER CAUSE YOU BELIEVE MAY HAVE CONTRIBUTED:
DESCRIBE THE CONDITION OF THE TOOTH PRIOR TO INJURY: □ SOUND/NATURAL □ FILLED □ CAPPED □ ARTIFICIAL □ OTHER _____	

Dentist must sign here:	Degree:		
Address:	City:	State:	Zip:
Date:	Tax Identification Number:		

TO EXPEDITE PROCESSING, YOU MAY RETURN THIS QUESTIONAIRRE, ALONG WITH YOUR VISIT NOTES AND STANDARDIZED BILLING FORMS, DIRECTLY TO THE CLAIMS ADMINISTRATOR AT:

Administrative Concepts, Inc.
994 Old Eagle School Road, Suite 1005
Wayne, PA 19087
TOLL FREE CUSTOMER SERVICE (888) 293-9229
FAX (610) 293-9299
EMAIL: aciclaims@visit-aci.com

Catlin Insurance Company, Inc.

RELEASE OF INFORMATION

Authorization Form

INSURED INFORMATION

Insured's Name_____ Date of Birth ____/____/____ Gender ☐ Male ☐ Female

Insured's Address _____

Policy Number _____ Phone Number _____ Social Security Number _____

I hereby authorize _____
(TREATING FACILITY/ PHYSICIAN/OTHER HEALTHCARE PROVIDER NAME HERE)
and its affiliates, employees and agents to release health information which identifies diagnosis, treatment, claims payment and healthcare services already provided or to be provided to:

_____ for _____
(Patient's full name) (dates of treatment)

Information should be released or mailed to: ☐ Individual ☐ Physician ☐ Institution ☑ Insurance Administrator

Administrative Concepts, Inc. **994 Old Eagle School Road, Suite 1005** **Wayne, PA 19087**	**Purpose:** **☑ Claims Payment ☐ Litigation** **☐ Medical Review ☐ Other:_____**

I request only the following information be released:

☐ ENTIRE MEDICAL RECORD ☐ Lab reports ☐ Operative Report ☐ X-Ray Report
☐ Emergency Room Report ☐ Pathology Report ☐ EKG ☐ X-Ray Film
☐ Admission History & Physical ☐ Cardiac Cath Lab Reports ☐ Itemized Billing Statement
☐ Discharge Summary ☐ Other _____

I understand this release includes personally identifiable information such as name, address, social security number and insurance identification number. I also understand that this information may be subject to re-release by this entity for the purpose of resolving insurance benefit coverage determinations. As such, this information may no longer be protected by applicable state and/or federal privacy laws.

This authorization shall be valid for one year (365 days) from the date of my signature below or until _____.
(insert date)

I have the right to revoke this authorization by providing written notice to the receiving entity listed above. However, this authorization may not be revocable if the entity, its employees or agents have already acted on this authorization prior to receiving my written revocation. I understand that this authorization is voluntary, and that I have a right to a copy of this authorization. Refusal to sign this authorization does not affect my eligibility for enrollment or payment of covered services.

Member Signature: _____ **Date:** _____
(If other than member, please sign below and include a copy of written proof of legal authorization to represent the member or his or her estate (i.e. Power of Attorney, Guardianship, Executor, other)

Name of Legal Representative, if applicable: _____

Signature of Legal Representative: _____ Date: _____

Name of Witness, if signed by Representative: _____

Signature of Witness, if signed by Representative: _____ Date: _____

NOTICE TO POLICYHOLDERS

FRAUD NOTICE

Alaska	A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
Arizona	For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas	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.
California	For your protection California law requires the following to appear on this form. Any person who knowingly presents 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.
Delaware	Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
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.
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.
Idaho	Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony.
Indiana	Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
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.
Louisiana	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.
Maine	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 denial of insurance benefits.
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.
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
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.

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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.
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.
New York	Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, 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 value of the subject motor vehicle or stated claim for each violation.
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.
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.
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.
Puerto Rico	**Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.**
Rhode Island	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.
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
Virginia	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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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 include imprisonment, fines and denial of insurance benefits.
NAIC Model	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.

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