Student Accident Insurance Claims Instructions

In case of accident, notify the school immediately. You may obtain a claim form from the school or you may download one from www.BollingerSchools.com or from the District's website www.sbschools.org.

- The claim form must be submitted directly to Bollinger within **90 days** from the date of accident.
- Treatment must commence within **90 days** from the date of injury.
- Attach itemized bills (***CMS-1500 form for physicians & UB-04 forms for Hospitals***) showing treatment, dates of treatment, and charges. **Balance due bills will not be accepted.**
- Attach copies of the corresponding primary insurance's explanation of benefits (EOB).
- If there is no primary insurance through the parent or guardian's employer, a statement of verification from employer on their letterhead must also be submitted.
- Itemized bills and explanation of benefits must be submitted within **90 days** from the date of treatment.
- Forward additional bills and EOB's to**: Bollinger, Inc., P. O. Box 1346, Morristown, NJ 07962.**
- Please note the name of school district on all bills and correspondence. **NO ADDITIONAL CLAIM FORM IS NECESSARY.**
- It is the parent's responsibility to complete their portion of the claim form, have it signed by the school nurse and submit the claim form to Bollinger. Do **NOT** leave original claim form at the hospital or physician's office.
- You may provide **copy** of the claim form to the hospital or physician's office so they can bill Bollinger directly.
- If you have any questions, once your claim has been submitted and processed by Bollinger, please call the Bollinger the Claims Department toll free at **(866) 267-0092**.

If you have any questions regarding claim reporting or issues with the processing of claims through Bollinger, contact Stephanie Brown, Claims Advocate at A.J. Gallagher, the School District's Insurance Agent, by phone toll free at (888) 232-9262, directly at (609) 430-4103, or claims fax at (609) 924-9221

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.: MCB5858701

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. 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 ☐ 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.	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.

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 _____