-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: **DIOCESE OF ALLENTOWN**	2. School Within Diocese Child Attends:		3. Master Policy No.: **N808**	
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 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.

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** _____

The accident insurance coverage purchased provides coverage on an **EXCESS** basis. Under this plan, the first $100 of covered charges are paid without regard to any other applicable coverage that may be in effect. After the first $100 in covered charges are paid, expenses which are **NOT** covered by your other personal or group insurance are eligible for coverage under this plan up to the policy limit.

Please follow these instructions when filing a claim:

1. **CLAIM FORMS MUST BE MAILED TO BOLLINGER WITHIN 90 DAYS OF THE DATE OF ACCIDENT.**
   Please be sure that:
   a) The school official has completed his/her section of the claim form.
   b) You have completed and signed the Parent's Statement and Authorizations.
   c) You have attached itemized bills to this form.
   d) The statement of Other Insurance section of the form must be completed.

2. If the claim totals more that $100, we will pay the first $100 and return the expenses to you for submission to your own personal or group insurance coverage.

3. If you have coverage through an HMO (or similar organization) you must comply with their requirements once the first $100 has been paid, or your remaining balances will not be covered under this policy.

4. After your own insurance has paid the medical expenses, attach the itemized bills (CMS-1500 from physicians and UB-04 from hospitals) and copies of the Explanation of Benefits from your primary insurance company to this claim form and mail to the address shown below. **We cannot accept balance due bills.**

5. The subsequent bills and Explanation of Benefits from your other insurance should be sent in as you receive them. Please write the claimant's name, policy number and date of accident on all subsequent bills. **A new claim form is not necessary.**

6. Please keep a copy of this Claim Form and all bills and primary insurance Explanations of Benefits for your own records.

If you need further information call 866-267-0092 or contact us on our website at www.BollingerSchools.com DO NOT CALL THE SCHOOL.

Than you for your cooperation.

PLAN ADMINISTRATION AND CLAIM SERVICE BY:

Bollinger
Insurance Solutions

P.O. BOX 706, SHORT HILLS, N.J. 07078-0706 • TELEPHONE (866) 267-0092

www.BollingerSchools.com