-PLEASE READ INSTRUCTIONS ON REVERSE SIDE 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.:
Corry Area School District		MCB 5858625

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 _____

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.

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

9 ☐ **We have a government funded plan (Medicaid, TriCare, etc)**

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. **THIS CLAIM FORM MUST BE MAILED TO BOLLINGER WITHIN 90 DAYS OF THE DATE OF THE 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 Medical Authorization (if applicable)
   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 than $100, we will pay the first $100 and return the expenses to you for submission to your own personal or group insurance coverage.

3. After your own insurance has paid the medical expenses, attach the itemized bills (CM-1500 from physicians, UB-04 from hospitals, and ADA Dental claim form J430 or its equivalent for dental injuries) 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 a balance due bill.**

4. 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.

5. After you have submitted your completed claim form and itemized bills to Bollinger Specialty Group you may go to www.BollingerSchools.com and click the Check Claim Status link to access the Explanation of Benefits.

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, DO NOT CALL THE SCHOOL.

Thank you for your cooperation.

FRAUD WARNING NOTICE

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.

PLAN ADMINISTRATION AND CLAIM SERVICE BY:

Bollinger Specialty Group
BOLLINGER, INC., A SUBSIDIARY OF
ARTHUR J. GALLAGHER & CO.

PO BOX 1346, MORRISTOWN, NJ 07960 – TELEPHONE 866-267-0092
www.Bollingerchools.com