BMI Benefits, LLC.
P.O. Box 511
Matawan, NJ 07747
Phone: 800.445.3126
Fax: 732.583.9610
www.bobmccloskey.com

Student Accident Claim Form

Please complete this form in its entirety and submit to BMI Benefits within 90 days from the date of accident. Please retain a copy for your records. Please contact the medical/dental providers where treatment was received, submit BMI's billing information as your secondary insurance, and ask for BMI to be billed directly. You should provide them with a copy of this form. You may also obtain from the medical/dental providers **all itemized bills** and **primary insurance explanation of benefits (EOBs)**. Itemized bills are considered **HCFA1500** Forms (physician's office), **UB-04** Forms (hospitals), and **ADA Dental Claim Forms** (dentist) **not balance due statements.** Please reference the attached claims instruction document for additional information.

PART 1A - POLICYHOLDER

School/Organization/Policyholder Name	Policy#
Diocese of Shreveport	WYB-1202-A-01

School/Organization/Policyholder Mailing Address (Street, City, State, Zip)

Student's Name	Date of Birth	Male ◯ Female ◯

Date of Injury	Time	Name of Activity or Sport Type	Body Part Injured	◯ Left Body Part ◯ Right Body Part

At the time of the accident, was the student involved in an activity sponsored and supervised by the Policyholder? ◯ YES ◯ NO

Sport/Activity Situation: ◯ Game ◯ Practice ◯ Conditioning ◯ Travel ◯ PE ◯ Recess ◯ Classroom ◯ Cafeteria ◯ Club ◯ Bus

How did Injury occur?

Name of School Official:	Title of School Official:

Signature of Supervisor/Official	Date

NOTE: Part 1A – Policyholder section must be signed by an official of the policyholder or the claim cannot be processed

PART 1B - INJURED PERSON INFORMATION & INSURANCE INFORMATION

Student's Social Security Number (SSN Must be provided as required by the Center for Medicare Services)

Student's Home Address (Street, City, State, Zip)

Is the Student covered by any other insurance policy, either as a dependent, or under a group, individual, automobile, medical or liability Policy? **YES** ◯ **NO** ◯ If Yes, Name of Ins. Carrier: _____ Policy #: _____

Is the above insurance a Medicaid Plan or a Military Insurance such as Tricare? **YES** ☐ **NO** ☐

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name		Parent/Guardian Name	
Phone	E-Mail	Phone	E-Mail
Is the Parent/Guardian Employed?	YES ◯ NO ◯	Is the Parent/Guardian Employed?	YES ◯ NO ◯

Medical Information Authorization: I authorize any Health Care Provider, Medical Facility, Doctor, Insurance Company or Organizatio furnish at the request of BMI Benefits, LLC. or the underwriting companies with which it works, information which you may possess inclu findings and treatments rendered and copies of all hospital and medical records for professional services and hospital care rendered on behalf. The foregoing authorization is granted with the understanding that any legal rights I may ordinarily have to claims communication between us as privileges are hereby expressly and voluntarily waived. A photostat of this authorization shall be considered as valid and as the original. Payments will be made to the providers of service unless a paid receipt/statement accompanies the medical claim submi **Important Notice:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an appli insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information conce 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 t dollars and the stated value of the claim for each such violation. (Fraud language varies by state, for additional state specific fraud warni language, please see below.)

Claimant or Authorized Person's Signature	Date

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Got You Covered

Statement of No Other Insurance

Please complete this form in its entirety and submit to BMI Benefits, LLC. along with the completed accident claim form.

Statement of No Other Insurance

I,_____, declare that I was not covered by any other insurance policy, through
(Insured's Name)
myself or my parents for the accident dated_____. Should any insurance become effective during my treatment I will notify BMI Benefits and forward all eligible bills to the new carrier. I understand BMI Benefits coverage is excess to all other insurance and will pay after all collectible insurance. I understand that if any of these statements are false it could deem my claim ineligible.

_____ _____
(Insured Name or Parent Name if insured is a minor) **(Date)**

_____ _____
(Insured Signature or Parent Signature if insured is a minor) **(Date)**

SCHOOL/POLICYHOLDER NAME: _____

FRAUD WARNING:
ANY PERSON WHO KNOWINGLY AND/OR WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY OR OTHER PERSONS, FILES A STATEMENT OF CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD AND SUBJECT TO CRIMINAL AND SUBSTANTIAL CIVIL PENALTIES.