HOW TO FILE A CLAIM:

1. Complete this form within 90 days.
2. Attach Itemized Bills and Primary Carrier Statements
3. Mail to: BMI Benefits, LLC, P O Box 511, Matawan, NJ 07747/1-800-445-3126 -- Fax: 732-583-9610

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.

Got You Covered

This part must be completed and signed by an official of the policyholder or the claim cannot be processed

PART 1A: POLICYHOLDER			
School/Organization		Policy#	Diocese of Shreveport#BAP 271994
School Mailing Address		City, State, Zip	
Injured Person's Name	Birth date	Male □	Female □
Date of Injury Time	Type of Sport	Part of body injured	
How did Injury occur?			
Sport Designation: Intercollegiate ☐	Intramurals☐	Practice ☐	Game ☐ Other ☐
At the time of the injury, was the injured involved in an activity sponsored and supervised by the policy holder?		YES ☐	NO ☐
Name of Supervisor	Was he/she a witness to the accident?	YES ☐	NO ☐
Signature of Supervisor/Official	Title	Date	

PART 1 B: INJURED PERSON'S INFORMATION **THE INJURED PERSON'S SOCIAL SECURITY NUMBER MUST BE PROVIDED AS REQUIRED BY THE CENTER FOR MEDICARE SERVICES**
Injured Person's Social Security Number
Injured Person's Home Address (Street, City, State, Zip)
Is the injured Person Employed? YES ☐ NO ☐ If yes, please fill out Section A below.
Is the injured Person Married? YES ☐ NO ☐ Spouse's Name
Is the Spouse Employed? YES ☐ NO ☐ If yes, please fill out Section B below.
Are you covered by any other insurance policy, either as a dependent, group, individual, automobile medical or liability YES ☐ NO ☐ If Yes: Name of Insurance Carrier _____ Policy #: _____

PARENT/GUARDIAN INFORMATION	
Father/Guardian Name	Mother/Guardian Name
Address (Street, City, State, Zip)	Address (Street, City, State, Zip)
Home Phone	Home Phone
Is the Father Employed? YES □ NO □	Is the Mother Employed? YES □ NO □

SECTION A (INSURED/FATHER)		**SECTION B (SPOUSE/MOTHER)**	
Employer		Employer	
Address (Street, City, State, Zip)		Address (Street, City, State, Zip)	
Business Phone		Business Phone	
Insurance Company	Policy#	Insurance Company	Policy#

MEDICAL INFORMATION AUTHORIZATION ASSIGNMENT OF BENEFITS:

You are hereby authorized to furnish at the request of and to BMI Benefits, LLC or the underwriting companies with which it works, information which you may possess; including findings and treatment rendered, X-rays and copies of all hospital and medical records, all occasioned by professional services and hospital care rendered on my behalf. The foregoing authorization is granted with the understanding that any legal rights I may ordinarily have to claim communications between us as privileged are hereby expressly and voluntarily waived. A Photostat of this authorization shall be considered as effective and valid as the original, PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Claimant or Authorized Person's Signature	Date