HOW TO FILE A CLAIM:

1. Complete this form within 90 days.
2. Attach Itemized Bills and Primary Carrier Statements
3. Send to: BMI Benefits, PO Box 511 Matawan, NJ 07747 PH: (800-445-3126) FAX: (732-583-9610) OR EMAIL: BMI@BobMcCloskey.com

Gallagher Student/BMI Benefits Volunteer Accident Claim Form

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.

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

PART 1A: POLICYHOLDER

Organization **Archdiocese of Cininnati** School: ___________________________________ Policy# KHH000455

School Mailing Address City, State, Zip

Injured Person's Name Birth date Male □ Female □

Date of Injury Time Part of body injured Type of Sport/Activity: If a sports injury list sport name:

If not sports related select activity: □ Classroom □ PE Class □ Recess
□ Zip lining □ Rope Course □ Trampolines □ Horseback Riding □ Inflatable Devices
□ Dunk Tanks □ Scuba Diving □ Rock Climbing □ Paintball/Airsoft □ Bungee Jumping □ Other

How did Injury occur?

Accident Designation: General Accident □ 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, Name of Employer:

Is the injured Person Married? YES □ NO □ Spouse's Name

Is the Spouse Employed? YES □ NO □ If yes, Name of Employer:

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 #: __________________________

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