



P.O. Box 390
Short Hills, NJ 07078

SECTION I TO BE COMPLETED BY CLAIMANT (REQUIRED)

1. NAME: (first) _____ (last) _____

2. ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

3. PHONE: _____

4. BIRTHDATE: _____ GENDER: Male Female

5. AFFILIATION: COACHES OFFICIALS SPEECH, DEBATE & THEATRE SPIRIT MUSIC

6. LEVEL OF PLAY: YOUTH HIGH SCHOOL COLLEGE ADULT

7. TYPE OF SPORT/ACTIVITY: _____

8. ACCIDENT DATE: 1/26/2009 ACCIDENT TIME: _____

9. BODY PART INJURED: _____

10. ACCIDENT OCCURRED DURING:

- GAME PRACTICE TOURNAMENT CAMP/CLINIC
 TRAVEL COMPETITION (MUSIC, SPEECH, DEBATE, THEATRE) OTHER

11. DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:

12. NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED:

PLEASE NOTE: A \$500 DEDUCTIBLE APPLIES. THE BENEFIT PERIOD IS 52 WEEKS

SECTION II STATISTICAL INFORMATION (REQUIRED)

1. TYPE: COMPETITIVE RECREATIONAL
2. LOCATION: ON FIELD SIDELINES SPECTATOR AREA
 OTHER
3. SURFACE: DIRT GRASS OUTDOOR TURF INDOOR TURF
4. SURFACE CONDITION: DRY/NORMAL WET/RAINY ICY MUDDY
5. ACTIVITY: RUNNING STANDING
 OTHER
6. STATUS: HIT BY OBJECT FELL COLLISION WITH OBJECT COLLISION WITH PLAYER
 OTHER

SECTION III POLICY INFORMATION

| POLICY EFFECTIVE DATE | POLICY EXPIRATION DATE | POLICY # | NAME OF POLICY HOLDER |
|-----------------------|------------------------|--------------|--|
| July 1, 2008 | July 1, 2009 | 4102AH243485 | National Federation of State High School Association |

SECTION IV

ASSIGNMENT OF BENEFITS

ALL CLAIMS BENEFITS WILL BE PAID DIRECTLY TO DOCTORS AND HOSPITALS INVOLVED UNLESS YOU PROVIDE PAID RECEIPTS FOR SERVICES RENDERED.

SECTION V

STATEMENT OF OTHER INSURANCE (REQUIRED)

NAME: _____
ADDRESS: _____
CITY: _____
STATE: _____ ZIP: _____
PHONE: _____
EMPLOYER: _____
EMPLOYER PHONE: _____
 EMPLOYED SELF-EMPLOYED UNEMPLOYED

If you are employed but have no insurance, you must include a letter of verification from you remployer on their letterhead that no insurance is provided to you (or to your dependents, if this claim is for your child) through your workplace.

IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND OR DENTAL INSURANCE POLICY? YES NO

IS CLAIMANT COVERED UNDER A GOVERNMENT SPONSORED INSURANCE SUCH AS MEDICARE/MEDICAID? YES NO

INSURED NAME: _____

ID#: _____

INSURED GROUP#/NAME: _____

COMPANY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

***Please include a copy of insurance card (both sides)**

Note: IF CLAIMANT IS A MINOR AND HAS MEDICAL INSURANCE COVERAGE AS AN ELIGIBLE DEPENDENT FROM EITHER PARENT'S PREVIOUS MARRIAGE AS MANDATED IN A DIVORCE DECREE, PLEASE GIVE NAME, ADDRESS AND PHONE NUMBER OF RESPONSIBLE PARTY

SECTION VI

AUTHORIZATION REGARDING PAYMENT OF BENEFITS

For services rendered or to be rendered I hereby authorize the Insurance Company or their representatives to pay benefits in connection with this accident or injury directly to the doctor, hospital or other provider of service. If paid receipts are submitted with this claim form, benefits will be paid to the insured..

SECTION VII STATEMENT OF CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION (REQUIRED)

1. 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 who makes a claim to receive benefits from this policy under false pretense; 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 substantial civil penalty to the extent allowed by state law.

I have read this statement and agree that the information provided for this claim is true and correct.

SIGNATURE OF CLAIMANT/PARENT (REQUIRED): _____ DATE: _____

2. I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by Bollinger Insurance or its representatives, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF CLAIMANT/PARENT (REQUIRED): _____ DATE: _____

IMPORTANT: ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED

1. Accident medical expense coverage under this policy is provided on an Excess Basis and benefits will only be paid under this plan after your own personal or group insurance (including Health Maintenance Organizations) has paid out its benefits. Please note that you must follow your primary insurance carrier's eligibility criteria (i.e., to be treated in-network, if required by HMO, etc) in order for this policy to consider your expenses for payment.

2. **Claim Guidelines:** You have **90** days from date of injury to submit claim form.

For claims to be eligible for coverage you must seek medical attention within **60 days** from date of injury.

Benefit Period: This policy is subject to a **52 week** eligibility period from date of injury. Medical or dental expenses that are incurred **within 52 weeks** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **52 week** benefit period will not be covered by this policy.

3. **Please Remember:**

- a. Advise your Doctors/Hospitals of this insurance so they can file claims directly to Bollinger
- b. Attach all Explanation of Benefits (EOB) forms that you have received from your Primary insurance carrier or other healthcare plan.
- c. **Itemized bills are required:** You must submit itemized bills; balance due bills will not be processed. See below for forms needed.
 1. HCFA-1500- standard form used by Providers
 2. UB-04 or UB-92-standard form used by Hospitals
 3. Payment of bills will follow the usual and customary guidelines. This means that the basis for payment of specific medical or dental claims is based on the average cost of that service by region. This policy does not automatically pay for services in full; it pays based on the "**usual and customary**" fee for that service in your area.

4. **Dental Bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before making a claim for dental treatment under this policy.

5. **Flex Spending, Health Reimbursement or Health Spending Accounts (HRA, HSA):** Please read below and follow the steps appropriately to submit information.

1. Employer contribution to flex account - Send to Primary insurance first, then flex account, then Bollinger
2. Employee contribution to flex account - Send to Primary insurance first, then Bollinger, then flex account. If monies have been paid out of your flex account before Bollinger then those monies will need to be reimbursed to your flex account by your Providers. In order for claims to be processed by Bollinger, proof of reimbursement to your flex account is needed.

For further Claims information contact:

Bollinger Sports Claims Department
P.O. box 390
Short Hills, NJ 07078-0390
Phone: 1-866-267-0093
Fax: 973-921-2876
www.BollingerNFHS.com

