COLLEGE CLAIM FORM

-PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING-

SEND ALL FORMS TO CLAIMS ADMINISTRATOR: BOLLINGER INC. P.O. Box 727 Short Hills, NJ 07078-0727

				Short ni	115, NJ U/0/8-0/2/
1. Name of College:				2. Master Polic	y No.:
3. Student's Last Name:	First Name:	4. Social Security Numb	er: 5. Date of Birth:	6. Sex:	7. Telephone Number:
8. Home Address:		City/State/Zip Co	de:		
IF CLAIM IS FOR INSURED D	EPENDENT:				
9. Patient's Last Name:	First Name:	10. Social Security Numb	per: 11. Date of Birth:	12. Sex: ☐ M ☐ F	13. Relationship to Student:
IF CLAIM IS FOR SICKNESS:					
14. Date Symptoms First Appeared:	ness:	s: 16. I		. Initial Treatment Date:	
IF CLAIM IS DUE TO ACCIDE	NT:				
17. Date of Accident: 18. Time:	□ A.M. 1	9. How Did Accident Occur	?		
20. Where Did Accident Occur?		21. Part of Bod	21. Part of Body Injured:		
RE: INTERCOLLEGIATE SPOR	T ACCIDENT				
22. If Intercollegiate Sport, Name of Sport: 23. I certify that the abov jured while participat of the intercollegiate		ove named claimant was in- pating in the practice or play the sport indicated in #22.		ic Official:	Title:
HEALTH CENTER REFERRAL:					
CENTER I did not go to	the Health Center becaus	se: (please check one)	Authorized Signature or twas an emergency		e Health Center was closed
PAYMENT AUTHORIZATION		(Give Reason)			
	y to the				
I hereby authorize payment of benefits directly providers rendering services.		lease Sign Here:	Parent or Insured (If A	Adult)	Date
MEDICAL AUTHORIZATION					
I hereby authorize the release of any medical tion necessary to process this claim, includin this and/or previous confinements and/or disc	g all data covering Pl	lease Sign Here:	Parent or Insured (If A	Adult)	Date
I hereby certify, swear and affirm that the in	formation given is true	and accurate. I fully under	stand that any willful misre	epresentation made I	by me in an attempt to collec

Date_

Signature_

Parent or Insured (If Adult)

STATEMENT OF OTHER INSURANCE - MUST BE COMPLETED

1. Father's Name:	2. Name and Address	2. Name and Address of His Employer:		
3. Mother's Name:	4. Name and Address of Her Employer:			
5. Name and Address of Claimant's Employer:			6. Yes I do have other personal or group medical insurance.	
Names of Other Insurance Companies		Address		
7. No, I do not have other personal group medical	insurance of any sort.			

INSTRUCTIONS

To avoid processing delays, please follow all instructions:

- 1. The student (not the Doctor or Hospital) must submit a fully completed claim form within 90 days of an accident or sickness. Only on form is needed for each accident/sickness.
- 2. Subsequent bills should clearly indicate patient name, name of College or Policy Number, and Diagnosis. All bills must be itemized a claims cannot be processed from balance due statements.
- 3. Intercollegiate Sports Accident claims must be signed by an authorized athletic official.
- 4. If a Health Center Referral is required, the Health Center questions must be fully completed.
- 5. The Statement of Other Insurance section above **MUST** be completed on policies where this plan is secondary to othe insurance. If employed with no insurance, a statement of verification from the employer must be submitted on their letterhead.
- 6. Please keep a copy of this Claim Form and all bills and primary insurance Explanations of Benefits for your records.

PLAN ADMINISTRATION AND CLAIM SERVICE BY:



P.O. BOX 727, SHORT HILLS, N.J. 07078-0727 • TELEPHONE (800) 526-1379