COLLEGE CLAIM FORM

-PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING-

SEND ALL FORMS TO CLAIMS ADMINISTRATOR:
BOLLINGER INC.
P.O. Box 1329
Morristown, NJ 07962

1. Name of College:				2. Master Policy No.:	
3. Student's Last Name: First Name:		4. I.D. Number:	5. Date of Birth:	6. Sex: ☐ M ☐ F	7. Marital Status ☐ M ☐ S
8. Mailing Address City/State/Zip Code:					9. Telephone Number:
10. Student's E-mail Address:					

IF CLAIM IS FOR INSURED DEPENDENT:

11. Patient's Last Name: First Name:	12. Date of Birth:	13. Sex: ☐ M ☐ F	14. Relationship to Student:

IF CLAIM IS FOR SICKNESS OR ROUTINE EXAM:

15. Date Symptoms First Appeared:	16. Reason for Visit:	17. Initial Treatment or Exam Date:

IF CLAIM IS DUE TO ACCIDENT OR INJURY:

18. Date of Accident or Injury: 19. Time: ☐ A.M. ☐ P.M.	20. How Did Accident or Injury Occur?	
21. Where Did Accident or Injury Occur?		22. Part of Body Injured:

RE: INTERCOLLEGIATE SPORT ACCIDENT

23. If Intercollegiate Sport, Name of Sport:	24. I certify that the above named claimant was injured while participating in the practice or play of the intercollegiate sport indicated in #23.	Signature of Athletic Official:	Title: Date:
25. Athletic Official's E-mail Address:			

HEALTH CENTER REFERRAL:

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26. ❑ Date seen at Health Center _____ Authorized Signature or Initial _____

❑ I did not go to the Health Center because: (please check one)

❑ I was not in the Area ❑ It was an emergency ❑ The Health Center was closed

❑ Other _____

PAYMENT AUTHORIZATION

I hereby authorize payment of benefits directly to the providers rendering services.

Please Sign Here: _____ _____

Parent or Insured (If Adult) Date

MEDICAL AUTHORIZATION

I hereby authorize the release of any medical or other information necessary to process this claim, including all data covering this and/or previous confinements and/or disability.

Please Sign Here: _____ _____

Parent or Insured (If Adult) Date

I hereby certify, swear and affirm that the information given is true and accurate. I fully understand that any willful misrepresentation made by me in an attempt to collect benefits under this policy constitutes fraud and is punishable by law.

Signature _____ **Date** _____

Insured or College Official (if applicable)

COLL-15

(SEE REVERSE SIDE)

STATEMENT OF OTHER INSURANCE - MUST BE COMPLETED

1. Father's Name:	2. Name and Address of His Employer:
3. Mother's Name:	4. Name and Address of Her Employer:
5. Spouse's Name:	6. Name and Address of Spouse's Employer
7. Name and Address of Claimant's Employer:	8. ☐ Yes I do have other personal or group medical insurance.

Names of Other Insurance Companies	Address

9. ☐ No, I am not covered under other personal group medical insurance of any sort. (CHECK ALL THAT APPLY)
   - ☐ Due to my age, I am no longer eligible for coverage under my parent's plan.
   - ☐ My parents are self-employed or unemployed.
   - ☐ My parents are employed but do not have health insurance. (You must submit a statement from employer verifying that there is no health insurance in force.)
   - ☐ I am an international student and my parent's insurance does not cover me in the U.S.
   - ☐ I and/or my spouse is not employed.
   - ☐ I and/or my spouse is employed but do not have any other health insurance.

   ☐ Other (please provide details below) _____

_____

_____

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 one form is needed for each accident/sickness.

2. Subsequent bills must be submitted within 90 days of the date of service and should clearly indicate patient name, name of College or Policy Number, and Diagnosis. All bills must be itemized as 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 other insurance.

6. Please keep a copy of this claim form, all bills and primary insurnace Explanations of Benefits for your records.

PLAN ADMINISTRATION AND CLAIM SERVICE BY:

Bollinger Specialty Group
BOLLINGER, INC., A SUBSIDIARY OF
ARTHUR J. GALLAGHER & CO.

P.O. BOX 1329, MORRISTOWN, NJ 07962 • TELEPHONE (866) 267-0092

FRAUD WARNING NOTICES

Your state may require the following notice: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas, District of Columbia, Louisiana, Maryland, New Mexico, Rhode Island, Texas, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to any insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
Delaware, Idaho, Indiana: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Kentucky, Pennsylvania: 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 conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Maine, Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N. H. Rev. Stat. Ann. § 638:20.
New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
New York: 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 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 violation.
Ohio: Any person that knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.
Oklahoma: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Oregon: 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 may be subject to prosecution for insurance fraud.