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: Archdiocese of Cincinnati  Policy#: 11KTT8190903

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

Gallagher | STUDENT HEALTH & SPECIAL RISK

# Archdiocese of Cincinnati
# Student Accident Insurance Claim Form Instruction Sheet

1. **Gallagher Student Health & Special Risk/BMI Benefits Accident/Injury Claim Form:** Part 1A must be completed and signed by the school. All other sections must be completed by the parent/guardian. If your child is uninsured please indicate on the claim form that there is no primary insurance and request a copy of the "Statement of No Insurance" Form to signed and returned.

2. **Ensure you give the medical provider BMI Benefit's information for billing purposes (see below). The provider will then submit all necessary paperwork for processing claims.** If you choose to submit claims yourself, you must attach copies of your primary carrier's Explanation of Benefits (EOB) and all itemized medical bills (known as Fifteen Hundred or UB form). The itemized medical bills should show the ICD-9 and CPT codes for the services provided, as well as other necessary information for insurance processing. **Balance due statements are not itemized bills.**

3. If you have already paid the medical service provider and wish to be reimbursed directly, please attach a paid receipt or statement that verifies the payment along with the itemized bills and primary EOBs.

4. Submit the completed claim form to BMI Benefits. Claims can be submitted via mail, fax, or e-mail.

| **Fax** | Mail | Email |
|---|---|---|
| 732-583-9610<br>Attn: Archdiocese of Cincinnati Student Accident Claims | BMI Benefits, LLC<br>PO Box 511<br>Matawan, NJ 07747 | gayle@bobmccloskey.com |

5. You may contact BMI Benefits at 800-445-3126 to discuss your claim. Please be aware that settlement of your claim may take several weeks to process. When contacting BMI Benefits, please have your claim form available to ensure prompt assistance.