College Claim Form

PLEASE READ INSTRUCTIONS BEFORE COMPLETING-

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

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 should clearly indicate patient name, name of College/University 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 selection above **MUST** be completed on policies where this plan is secondary to other 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 Explanation of Benefits for your records.

Claims Questions Can Be Answered At (866) 267-0092

1. Name of College/University:			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. Home Address: City/State/Zip Code:				9. Telephone Number:

IF CLAIM IS FOR INSURED DEPENDENT:

10. Patient's Last Name, First Name	11. I.D. Number	12. Date of Birth	13. Sex [ ] M [ ] F	14. Relationship to Student:

IF CLAIM IS FOR SICKNESS:

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

IF CLAIM IS DUE TO ACCIDENT:

18. Date of Accident or Injury: 19. Time: [ ] A.M. [ ] P.M .	20. How Did Accident Occur?
21. Where did accident 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:

HEALTH CENTER REFERRAL:

25 ☐ 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 (give reason)____

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**___________________________

Parent or Insured (if Adult)

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
Name of other Insurance Companies	**Address**

9. No, I am not covered under other personal or 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. (You must submit a statement from employer verifying that there is no health insurance in force.)
[ ] Other (please provide details)

PLAN ADMINISTRATION AND CLAIM SERVICE BY:

P.O. BOX 727, SHORT HILLS, N.J. 07078-0727 * TELEPHONE (866) 267-0092