BOB MCCLOSKEY INSURANCE/ BMI BENEFITS, L.L.C

Bob McCloskey Insurance provides insurance benefits for all students for the treatment of bodily injury resulting from accidents occurring during the practice and play of intercollegiate sports (which may include other activities as specified in your policy).

CLAIM FORM

(1) The claim form must be completed in full and signed by the appropriate school official. Please be sure to detail accident information, include part of the body injured, how the injury occurred and the particular sport. A separate claim form (Part 1A) is required for each injury.

(2) Please have the student complete Part 1B of our claim form in full (Parent/Insured Information). We recommend that medical history and parent insurance information forms be completed prior to any athletic participation. Please keep this information on file in your office. If your institution provides their own parent insurance information forms, please attach a completed copy to Part 1A of our claim form. If there is no evidence of other valid and collectible insurance, we must still receive the completed form to process the claim. If you do not have this information on file, Part 1B must be completed in full before any payment of benefits can be considered.

(3) If the student does not have contact with a parent, please indicate this in Part 1B. Students that are independent of their parents need to write a short letter indicating this information. The letter must be signed by the student and dated.

(4) Please have the student sign and date the portion of the claim form indicating “Medical information authorization/Assignment of benefits”.

ITEMIZED BILLS

(1) Attach itemized copies of all applicable bills, including those bills under any deductible your plan may have. Also, include those bills paid partially or in full by other insurance. Bills showing only “Balance forward” or “Balance due” are not acceptable.

(2) An itemized bill indicates the provider of service’s full name and mailing address, type of service, date of service, fee charged and diagnosis. We will request any missing information from the provider of services. To assure quick processing, please be sure that the bill and the insurance statements submitted are for the same item. You will receive a copy of any correspondence. Feel free to offer our toll free number to any provider who wished to contact us.

(3) When sending additional bills and other insurance statements, please identify your school’s name and the name of the injured athlete.
OTHER INSURANCE INFORMATION

(1) Your institution has purchased an insurance plan that provides benefits in excess of those expenses not paid or payable by any other valid or collectible insurance. Without this provision, the cost of athletic insurance would be prohibitive.

(2) Along with the itemized bill, include a copy of the explanation of benefits statement from the other insurance carrier. If any or all benefits are denied by other insurance, we will need a copy of the denial showing the reason charges were denied. (Include front and back of explanation of benefits when necessary)

(3) In the event the student is not covered by any other collectible insurance through the student’s or their parent’s place of employment, we will request a letter from the appropriate employers verifying that no other coverage exists. The student can, also, provide a letter on company letterhead from the necessary employers verifying coverage does not exist at the time the claim is submitted.

HMO/PPO BENEFITS

(1) If an injured athlete has these types of insurance plans, we recommend you refer them to their primary care physician or obtain authorization that will allow you to use a non-network provider whenever possible. If it is not possible to use the network and payment of benefits are denied, you must provide us with the written statement of denial. If your institution has purchased a plan that will respond if an injured athlete goes “out of network”. Then benefits will be payable. If this provision is not part of your plan, benefits will be denied.

(2) It is to your advantage to use these services as they can considerably reduce those amounts paid by the excess insurance purchased by your institution. The insurance premiums you pay are based on losses paid by your accident insurance.
HOW TO FILE YOUR CLAIM:
1. Complete this form within 90 days
2. Deliver itemized bills and primary carrier statements.
3. Mail to: BMI Benefits, LLC, P.O. Box 511, Maltzan, NJ 07747 / 1-800-445-3126

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.

* all dates must be in the mm/dd/yyyy format

PART 1A: POLICY HOLDER

This part must be completed and signed by an official of the policyholder or the claim cannot be processed.

School/Organization: [Gettysburg College]
Address:

Injured Person's Name: [Blank] Male  Female  Date of Birth: [Blank]
Injury Date: [Blank] Type of Sport or Activity: [Blank]
Where and how did accident occur? (Be specific - Identify part of body and nature of injury.)

At the time of injury, was the injured involved in an activity sponsored and supervised by the policyholder? YES  NO  
Name of Supervisor/Official: [Blank] Was he/she a witness to the accident? YES  NO  
Signature of Supervisor/Official: [Blank] Title: [Blank] Date: [Blank]

PART 1B: INSURED INFORMATION

THE INJURED PERSON'S SS# MUST BE PROVIDED AS REQUIRED BY THE CENTER FOR MEDICARE SERVICES.

Injured Person's Social Security Number:
Injured Person's Home Address:
City/State/Zip: Home Phone: Cell Phone:

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: [Blank]
Is the spouse employed? YES  NO  If yes, please fill out Section B below.

PARENT/GUARDIAN INFORMATION

Father/Guardian Name: [Blank] Mother/Guardian Name: [Blank]
Address: Address:
City/State/Zip: City/State/Zip:
Home Phone: Home Phone:

Is father employed? YES  NO  If yes, please fill out Section A below.
Is mother employed? YES  NO  If yes, please fill out Section B below.
### SECTION A (INSURED/FATHER)

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### SECTION B (SPOUSE/MOTHER)

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**MEDICAL INFORMATION AUTHORIZATION ASSIGNMENT OF BENEFITS:**

You are hereby authorized to furnish at the request of and to BMI Benefits, LLC or their representatives information which you may possess; including findings and treatment rendered, X-rays and copies of all hospital or 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.

Claim Form Fraud Statement

**FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED:** 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.

**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.

**CALIFORNIA:** For your protection California law requires the following to appear on this form. Any person who knowingly presents a 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 an 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.

**FLORIDA:** WARNING: 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.

**NEW HAMPSHIRE:** Any person who with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 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.

**VIRGINIA:** Please NOTE that these fraud warnings DO NOT apply in the State of Virginia.

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https://webportal.bobmccloskey.com/claim_form.php

12/10/2015