Got You Covered

HOW TO FILE YOUR CLAIM:
1. Complete this form within 90 days
2. Attach itemized bills
3. Mail to: Olga Bobylak, The Vozza Agency, P.O. Box 100, Park Ridge, NJ 07656 / Tel: 201-307-8612

Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. Residents of the following states, please see last page: CA, CO, FL, NY, TN and VA.

PART 1A: POLICYHOLDER

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

School/Organization _____ Policy# 11KTT831770/4102AH402320

Address _____

Injured Person's Name_____ Male____ Female____ Date of Birth_____

Injury Date:_____ Time:_____ Type of Sport or Activity: _____

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 _____ Was he/she a witness to the accident? YES____NO____

Signature of Supervisor/Official _____Title _____ Date_____

PART 1B: INSURED INFORMATION

THIS PORTION MUST BE FILLED OUT COMPLETELY BEFORE CLAIMS CAN BE PROCESSED

Injured Person's Social Security Number:_____

Injured Person's Home Address_____

City/State/Zip _____Home Phone: _____ College Phone: _____

Is the injured person employed? Y/N ____ If yes, please fill out Section A below.

Is the injured person married? Y/N _____ Spouse's Name: _____

Is the spouse employed? Y/N _____ If yes, please fill out Section B below.

Parent/Guardian Information

Father/Guardian Name_____	Mother/Guardian Name _____
Address _____	Address _____
City/State/Zip _____	City/State/Zip _____
Home Phone: _____	Home Phone: _____
Is father employed? Y/N __ If yes, fill out section A.	Is mother employed? Y/N __ If yes, fill out section B.

SECTION A (INSURED/FATHER)	SECTION B (SPOUSE/MOTHER)
Employer: _____	Employer _____
Address _____	Address _____
City/State/Zip _____	City/State/Zip _____
Phone _____	Phone _____
Insurance Company _____	Insurance Company _____
Policy # _____	Policy# _____

Affidavit I verify that the statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the Company to the extent for which the Company would not have been liable.

Authorization

to Release Information I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to BMI Benefits, LLC, its employees, and authorized agents for the purpose of validation and determining benefits payable. I further authorize BMI Benefits, LLC to furnish the Policyholder or its agents, any and all information with respect to my insurance claim for the purpose of assisting with claims adjudication. This data may be extracted for audit or statistical purposes. I understand that I have the right to revoke this authorization in writing at any time and that such a revocation is not effective to the extent that such authorization has already been relied upon.

Payment Authorization I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices, unless paid receipts accompany this form.

Signature (parent or guardian if the claimant is a minor): X_____ **Date:**_____