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. PO Box 511, Matawan, NJ 07747 Fax: 732-583-9610 / Phone: 800-445-3126

BMI Benefits, LLC. Accident Claim Form

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.

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

PART 1A: POLICYHOLDER

School/Organization	Policy#	
School Mailing Address	City, State, Zip	
Injured Person's Name	Birth date	Male ☐ Female ☐
Date of Injury Time	Type of Sport /Activity	Part of body injured
How did Injury occur?		
Accident Type: Interscholastic ☐ Classroom☐ PE Class ☐ Recess ☐ 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

BMI BENEFITS, L.L.C
Claim Instructions Sheet

CLAIM FORM

(1) Please have the student complete Part1B 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.

(2) If the student does not have contact with a parent, please indicate this in Part1B. 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.

(3) 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.