BMI Benefits
FULL TPA SERVICES

**P.O. Box 511**
**Matawan, NJ 07747**
**Phone: 800.445.3126**
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**www.bobmccloskey.com**

# Student & Sports Accident Claim Form

Please complete this form in its entirety and submit to BMI Benefits within 90 days from the date of accident. Please retain a copy for your records. Please contact the medical providers where treatment was received, submit BMI's billing information as your secondary insurance, and ask for BMI to be billed directly. You may also obtain from the medical providers **all itemized bills** and **primary insurance explanation of benefits (EOBs)**. Itemized bills are considered **HCFA1500** Forms (physician's office), **UB-04** Forms (hospitals), and **ADA Dental Claim Forms** (dentist) **not balance due statements.**

## PART 1A - POLICYHOLDER

| College/University (Policyholder Name) | | Policy# |
|---|---|---|
| Greenville University | | COL L004020290901 |

| Student's Name | Date of Birth | ☐ Male ☐ Female |
|---|---|---|
| | | |

| Date of Injury/Accident | Name of Sport (if applicable) | Body Part Injured | ◯ Left Body Part ◯ Right Body Part |
|---|---|---|---|
| | | | |

**Type of Sport/Activity:** ☐ Intercollegiate Sport ☐ Club Sport ☐ Intramural Sport ☐ General Accident

**Sport/Activity Situation:** ☐ Game ☐ Practice ☐ Conditioning ☐ Travel ☐ Other: _____

**Was the student involved in an activity sponsored and supervised by the Policyholder?** YES ☐ NO ☐

**How did Injury occur? Please Provide Details of What Happened.**

| Name of College/University Official: | Title of College/University Official |
|---|---|
| | |

| Signature of College/University Official | Date |
|---|---|
| | |

***NOTE: Part 1A – Policyholder section must be signed by an official of the policyholder or the claim cannot be processed***

## PART 1B - INJURED PERSON INFORMATION & INSURANCE INFORMATION

**Student's Social Security Number (SSN Must be provided as required by the Center for Medicare Services)**

**Student's Home Address (Street, City, State, Zip)**

| Student's Phone # | Student's E-Mail |
|---|---|
| | |

**Is the Student covered by any other insurance policy, either as a dependent, or under a group, individual, automobile, medical or liability Policy?** YES ☐ NO ☐ **If Yes, Name of Ins. Carrier:** _____ **Policy #:** _____

**Is the above insurance a Medicaid Plan or a Military Insurance such as Tricare?** YES ☐ NO ☐

## PARENT/GUARDIAN INFORMATION

| Parent/Guardian Name | | Parent/Guardian Name | |
|---|---|---|---|
| | | | |
| **Phone** | **E-Mail** | **Phone** | **E-Mail** |
| | | | |
| **Is the Parent/Guardian Employed?** | YES ☐ NO ☐ | **Is the Parent/Guardian Employed?** | YES ☐ NO ☐ |
| **Employer** | | **Employer** | |

**Medical Information Authorization:** I authorize any Health Care Provider, Medical Facility, Doctor, Insurance Company or Organization to furnish at the request of BMI Benefits, LLC. or the underwriting companies with which it works, information which you may possess including, findings and treatments rendered and copies of all hospital and medical records for 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 claims communications between us as privileges are hereby expressly and voluntarily waived. A photostat of this authorization shall be considered as valid and effective as the original. Payments will be made to the providers of service unless a paid receipt/statement accompanies the medical claim submission. **Important Notice:** 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.
**For residents of New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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. (Fraud language varies by state, for additional state specific fraud warning language, please see below.)

| Student or Authorized Person's Printed Name & Signature | Date |
|---|---|
| | |

## IMPORTANT NOTICE

**For residents of Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
**For residents of 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.
**For residents of 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.
**For residents of 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.
**For residents of Delaware and Idaho:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.
**For residents of Florida:** 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.
**For residents of Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
**For residents of Kansas:** 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.
**For residents of Kentucky:** 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.
**For residents of Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
**For residents of Maine, Tennessee, Virginia and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
**For residents of Minnesota**: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
**For residents of New Hampshire:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
**For residents of New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
**For residents of New Mexico:** 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 CIVIL FINES AND CRIMINAL PENALTIES.
**For residents of Ohio and Oklahoma:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
**For residents of Oregon:** 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 may be guilty of a crime and may be subject to fines and confinement in prison.
**For residents of Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 subjects such person to criminal and civil penalties.
**For residents of Vermont:** Any person who knowingly presents a false statement in a claim for proceeds of an insurance policy may be guilty of a criminal offense and subject to penalties under state law.

Bob McCloskey Insurance
BMI BENEFITS - FULL TPA SERVICES

# Statement of No Other Insurance

Please complete this form in its entirety and submit to BMI Benefits, LLC. along with the completed accident claim form

I, _____, declare that I was not covered by any other
(Insured's Name)
insurance policy, through myself, my parents or my guardian for the accident dated _____ which occurred at my school. Should any insurance become effective during my treatment I will notify BMI Benefits and will forward all eligible bills to the new insurance carrier. I understand BMI Benefits coverage is excess to all other insurance and will pay after all collectible insurance. I understand that if any of these statements are false it could deem my claim ineligible.

_____ _____
(Insured Name or Parent/Guardian Name if insured is a minor) (Date)

_____ _____
(Insured Signature or Parent/Guardian Signature if insured is a minor) (Date)

**SCHOOL/POLICYHOLDER NAME:** Greenville University

**FRAUD WARNING:**
**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.**

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