



HOW TO FILE YOUR CLAIM:

1. Complete this form within 90 days
2. Attach itemized bills and primary carrier statements.
3. Mail to: BMI Benefits, LLC, P O Box 511, Matawan, 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

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# _____
Address _____

Injured Person's Name _____ Male _____ Female _____ Date of Birth _____
Injury Date: _____ Time: _____ Type of Sport or Activity: _____ *Intramural Interscholastic Other* _____
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: _____ Cell 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)

Employer: _____
Address _____
City/State/Zip _____
Phone _____
Insurance Company _____
Policy # _____

SECTION B (SPOUSE/MOTHER)

Employer _____
Address _____
City/State/Zip _____
Phone _____
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 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.

Claimant or Authorized Person's Signature

Date

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.