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: Lake Wales Charter Schools, Inc.

Policy#: SRG 0009144734

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 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 (Part1A) is required for each injury.

(2) 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.

(3) 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.

(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.

BMI Benefits, LLC
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Matawan, NJ 077447
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