

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	
Date of Injury	Time	Type of Sport	Part of body injured
How did Injury occur?			
Accident Type: Interscholastic <input type="checkbox"/> Classroom <input type="checkbox"/> PE Class <input type="checkbox"/> Recess <input type="checkbox"/> Other <input type="checkbox"/>			
At the time of the injury, was the injured involved in an activity sponsored and supervised by the policy holder? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Name of Supervisor		Was he/she a witness to the accident? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)
Are you covered by any other insurance policy, either as a dependent, group, individual, automobile medical or liability YES <input type="checkbox"/> NO <input type="checkbox"/>
If Yes: Name of Insurance Carrier _____ Policy #: _____
Is the above insurance a Medicaid Plan or a Military Insurance such as Tricare YES <input type="checkbox"/> NO <input type="checkbox"/>

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 <input type="checkbox"/> NO <input type="checkbox"/>	Is the Mother Employed? YES <input type="checkbox"/> NO <input type="checkbox"/>

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
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