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

Got You Covered

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 Haverhill High School Policy# PAI L00490140 002

Address 137 Monument St. Haverhill, MA 01832

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