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, 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.

Got You Covered

This part must be completed and signed by an official of the policyholder or the claim cannot be processed

PART 1A: POLICYHOLDER

School/Organization: Felician College Policy# SRG 0009150073

Mailing Address where Insurance Info/Request should be mailed City, State, Zip

Injured Person's Name Birth date Male ◯ Female ◯

Date of Injury Time Type of Sport Part of body injured

How did Injury occur?

Sport Designation: Intercollegiate ◯ Intramurals ◯ Practice ◯ Game ◯ 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

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.

CALIFRONIA: 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.