Bollinger Specialty Group
A Gallagher Company

COLLEGE CLAIM FORM

-PLEASE READ INSTRUCTIONS ON THE NEXT PAGE BEFORE COMPLETING-

SEND ALL FORMS TO CLAIMS ADMINISTRATOR:
Bollinger Specialty Group
PO Box 1329
Morristown, NJ 07962
or email to:
BollingerCollegeClaims.GBS@AJG.com

1. Name of College:				2. Master Policy No.:	
3. Student's Last Name: First Name:	4. I.D. Number:	5. Date of Birth:	6. Sex: ☐ M ☐ F	7. Marital Status ☐ M ☐ S	
8. Mailing Address	City/State/Zip Code:			9. Telephone Number:	
10. Student's E-mail Address:					

IF CLAIM IS DUE TO ACCIDENT OR INJURY:

11. Date of Accident or Injury:	12. Time: ☐ A.M. ☐ P.M.	13. How Did Accident or Injury Occur?
14. Where Did Accident or Injury Occur?		15. Part of Body Injured:

AUTHORIZATIONS AND STATEMENT OF OTHER INSURANCE MUST BE COMPLETED

MEDICAL AUTHORIZATION: I authorize the release of any medical or other information necessary to process this claim, including all data covering this and/or previous confinements and/or disabilities.

SIGNED ______________________ DATE __________

PAYMENT AUTHORIZATION: I authorize payment of medical benefits directly to the providers rendering services.

SIGNED ______________________ DATE __________

STATEMENT OF OTHER INSURANCE

1. Father's Name:	2. Name and Address of His Employer:
3. Mother's Name:	4. Name and Address of Her Employer:
5. Spouse's Name:	6. Name and Address of Spouse's Employer
7. Name and Address of Claimant's Employer:	8. ☐ Yes I do have other personal or group medical insurance.

Names of Other Insurance Companies	Address

9. ☐ No, I am not covered under other personal group medical insurance of any sort. (CHECK ALL THAT APPLY)
- ☐ Due to my age, I am no longer eligible for coverage under my parent's plan.
- ☐ My parents are self-employed or unemployed.
- ☐ My parents are employed but do not have health insurance. (You must submit a statement from employer verifying that there is no health insurance in force.)
- ☐ I am an international student and my parent's insurance does not cover me in the U.S.
- ☐ I and/or my spouse is not employed.
- ☐ I and/or my spouse is employed but do not have any other health insurance.
- ☐ Other (please provide details below)

☐ **We have a government funded plan (Medicaid, Tricare, etc.)** If you have Medicare, please supply us with a copy of your card.

I hereby certify, swear and affirm that the information given is true and accurate. I fully understand that any willful misrepresentation made by me in an attempt to collect benefits under this policy constitutes fraud and is punishable by law.

Signature ______________________________ **Date**
Insured

INSTRUCTIONS

To avoid processing delays, please follow all instructions:

1. The student (not the Doctor or Hospital) must submit a fully completed claim form within 90 days of an accident. Only one form is needed for each accident.

2. The Statement of Other Insurance section above **MUST** be completed on policies where this plan is secondary to other insurance.

3. **MAIL THIS CLAIM FORM TO BOLLINGER SPECIALTY GROUP WITHIN 90 DAYS OF THE DATE OF THE ACCIDENT.**

4. Once you have sent in this claim form to Bollinger, submit a claim for all medical expenses to the company that administers your personal or group insurance (including Major Medical coverage).

   After your primary insurance has paid the medical expenses, up to the policy limits, submit all Bills (CMS-1500 from physicians and UB-04 from hospitals) with the corresponding Explanation of Benefits from your primary insurance company as you receive them and mail to the PO Box shown below. If you have paid any bills, you must include a receipt(s) or payment will be sent to the provider rendering the services.

   If this is a dental injury, your provider should submit injury related services only on an ADA Dental Form J430 or its equivalent and copies of corresponding Explanation of Benefits from your primary insurance company.

   We cannot accept balance due bills, statements, invoices or ledgers.

5. Subsequent bills should be mailed in as you receive them. Please show the student's name, policy number, and date of the accident on all correspondence. An additional claim form is not necessary.

6. Please keep a copy of this Claim Form, all bills and primary insurance Explanation of Benefits for your own records.

7. If you need further information or have any questions, please call 866-267-0092 to speak to one of our highly qualified Customer Service Representatives between the hours of 8 a.m. and 5 p.m. E.S.T. Monday - Friday or contact us on our website www.BollingerColleges.com.

8. After you have submitted your completed claim form and have received your first Explanation of Benefits from Bollinger Specialty Group, you will now have a claim number and you may go to www.BollingerColleges.com to enroll and check the status of your claim online.

PLAN ADMINISTRATION AND CLAIM SERVICE BY:

Bollinger Specialty Group
A Gallagher Company

P.O. BOX 1329, MORRISTOWN, NJ 07962 • TELEPHONE (866) 267-0092
FAX 973-921-2876