ROXBURY TOWNSHIP PUBLIC SCHOOLS
BOARD OF EDUCATION BUSINESS OFFICE
42 North Hillside Avenue, Succasunna, NJ 07876

Phone (973) 584-6099 www.roxbury.org Fax (973) 584-0426

August 2023,

The Board of Education has purchased an ***accident policy*** for all students covering them for all interscholastic sports, and the following activities:

Band, Cheerleading, Majorette, Intramural Sports, Non-Sport Extracurricular Activities, Flag Football, Gym Class, Volunteers, Student Coaches-Managers-Trainers, & Recess.

This program is written on what is referred to as an "EXCESS MEDICAL BASIS". In the event of an accident, the initial billing is done through the individual's primary health insurance carrier. The outstanding portion of your bill can be submitted to Bollinger Inc. for reimbursement.

CLAIMS:

The key to a smooth and cooperative effort on the part of all concerned is the prompt filing of a claim form, which is obtainable at the nurse's office. In the event of an injury, all claims must be reported to Bollinger Inc. ***within 90 days*** of the accident.

Thank you for your attention to this matter.

Sincerely,

Mr. Joseph Mondanaro
School Business Administrator
Board Secretary

2023-24
Student Accident Claim Form
Please Read Instructions On The Next Page Before Completing

SEND ALL FORMS TO:
CLAIMS ADMINISTRATOR
Bollinger Specialty Group
P.O. Box 1346
Morristown, NJ 07962
or email to:
BollingerSchoolClaims.GBS@AJG.com

1. School District or Diocese:	2. School Within District or Parish Child Attends:	3. Master Policy No.:

4. Claimant's Last Name: First Name:	5. Date of Birth:		6. Telephone:

7. Home Address:	8. City/State/Zip Code:

9. Personal Email Address of Parent or Guardian:

10. **Check activity in which student was involved when injured:**

A. ☐ Interscholastic Sports_____
Name of Sport

B. ☐ Cheerleading ☐ Twirling or Flagwaving ☐ Band Member

OR:

01 ☐ Physical Ed. Class
02 ☐ Classroom or Hallway
03 ☐ Playground (NOT Phys. Ed.)
04 ☐ To and From School
05 ☐ Group Travel
06 ☐ Non-School Activity (24 Hr. Plan)
07 ☐ Extra Curr. Activity ON Premises
08 ☐ Extra Curr. Activity OFF Premises
09 ☐ Spectator

Was School in Session? YES ☐ NO ☐ Starting Time _____ **Dismissal Time** _____

11. Date of Accident:	12. Time: ☐ A.M. ☐ P.M.	13. How Did Accident Occur?

14. Where Did Accident Occur?	15. Part of Body Injured:

16. I certify that the activity checked above is school sponsored and supervised and is covered under a policy applied for and purchased by the policyholder.

Signature of School Official _____ Title _____ Date _____

Email Address_____ Phone Number _____

AUTHORIZATIONS AND STATEMENT OF OTHER INSURANCE MUST BE COMPLETED BY PARENT OR GUARDIAN

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 _____

1. Parent/Guardian Name:	2. Name and Address of Employer:
3. Parent/Guardian Name:	4. Name and Address of Employer:

5. ☐ No, we do not have any personal or group medical insurance. I have enclosed a letter from my employer verifying this.
☐ We have no other insurance. We are (please check one): ☐ Self-employed ☐ Unemployed ☐ Disabled
☐ Yes, we do have other insurance. (Please complete #6).
☐ **We have a government funded plan (Medicaid, Tricare, etc.).** If you have Medicaid, please supply us with a copy of your card.

6. Names of other Insurance Companies	Address

I hereby certify, swear and affirm that the information given above 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.

Parent or Guardian's Signature: _____ **Date** _____

PARENTS: PLEASE READ ALL INSTRUCTIONS BEFORE FILING A CLAIM:

1. **THIS FORM SHOULD BE MAILED, E-MAILED OR FAXED TO RPS BOLLINGER WITHIN 90 DAYS OF THE DATE OF ACCIDENT TO ESTABLISH YOUR CHILD'S FILE.**

   MAIL TO CLAIMS ADMINISTRATOR: Bollinger Specialty Group, PO Box 1346, Morristown, NJ 07962

   E-MAILTO: bollingerschoolclaims.gbs@ajg.com with your child's name in the subject line. FAX TO:

   973-921-2876. Please make sure you include a cover page with the following:
   ATTENTION SCHOOL CLAIMS DEPARTMENT.

The Accident insurance coverage purchased by the Board of Education/School provides coverage on an **EXCESS BASIS** only. This means that only those medical expenses which are **NOT** payable by your own personal or group insurance are eligible for coverage under this policy, subject to the limitations and exclusions.

Please be sure that:

1. The school completes the top portion of this claim form, up to and including #17. A parent completes the bottom portion, signs and dates the form, then sends a copy to Bollinger Specialty Group.

   Once you have sent this claim form to Bollinger Specialty Group, have all bills submitted to your personal or group insurance (including Major Medical coverage).

2 After your health insurance has processed the medical expenses, have the providers submit itemized bills **(UB04 for a Hospital/Facility & CMS-1500 for all providers)** with the corresponding Explanation of Benefits from your primary insurance company. Please note, if you have paid providers, all forms and proof of payment may be submitted for reimbursement. **Please do not submit balance due statements, non-itemized invoices or ledgers.**

   If this is a **dental injury**, the dentist should submit injury related services only on **ADA Dental Form J430** and copies of corresponding Explanation of Benefits from your primary insurance.

3 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 visit our website @ **www.bollingerschools.com** to enroll in our online portal to check the status of your child's claim.

PLEASE DO NOT CALL THE SCHOOL.

If you have any questions on the process, please call 866-267-0092 between the hours of 8 am and 4:15 pm E.S.T. Monday – Friday. If you are unavailable during our regular business hours, please feel free to leave a message and our Customer Service Team will contact you the next business day.

PLAN ADMINISTRATION AND CLAIM SERVICE BY:

Bollinger Specialty Group
A Gallagher Company

P.O. BOX 1346, MORRISTOWN, N.J. 07962
TELEPHONE 866-267-0092
FAX 973-921-2876

www.BollingerSchools.com

Bollinger Specialty Group
A Gallagher Company

2023-2024 Student Accident Insurance

Claims Filing Instructions

Cut out or Show Your Medical Provider

Bollinger Specialty Group A Gallagher Company **Student Accident** **(Secondary/Excess Insurance)** Providers & Hospitals, please bill Bollinger Specialty Group directly including the name of Patient, Name of District, Diocese or Independent School and Diagnosis on all bills. *This is not a contract of insurance. The terms and conditions of coverage are set forth in the Policy issued to the school / Policyholder. The Policy is subject to the laws of the state in which it was issued.*	*	**SEND ALL FORMS TO CLAIMS ADMINISTRATOR:** **Bollinger Specialty Group** **PO Box 1346** **Morristown, NJ 07962** **or email to:** **BollingerSchoolClaims.GBS@AJG.com** **Questions: Please contact our Customer Service Department @ 1-866-267-0092**

FREQUENTLY ASKED QUESTIONS

Q. What is the purpose of Secondary/Excess Accident Insurance?

A. The coverage is intended to help cover medical expenses related to a covered injury that results from your participation in school's activities. The policy pays **after** any other valid/collectible insurance that the student carries. It is designed to cover expenses left to the patient's responsibility on their primary insurance Explanation of Benefits (EOB), such as co-pays, deductibles, and coinsurance for eligible medical treatment, subject to policy limitations and exclusions.

Q. In addition to the Claim Form, what documents are needed in order for the Student Accident Insurance to process a claim?

A. The provider must submit the following documents to the Claims Administrator, Bollinger Specialty Group:

1) Itemized Medical Bill – The provider will either bill the claims administrator with a CMS 1500 or UB04, and it will contain the following information:
   - Provider's Name and address
   - Tax ID Number
   - Date(s) of Service
   - Diagnostic Code(s) and Procedure Code(s)
   - The Fee for Each Procedure

2) Primary Explanation of Benefits (EOB) – This is a statement from your primary insurance company that outlines what charges will be covered or denied, and what will be left as patient responsibility (co-pay, coinsurance, deductible, etc.).

Fraud Warning

Please review the specific fraud warning for your school or college's location prior to signing the attached form or application.

All Other States: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 subjects such person to criminal and civil penalties.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas/Louisiana/Rhode Island/West Virginia: 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.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent information to obtain or amend insurance coverage or to make a 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.

District of Columbia: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: 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.

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 subjects such person to criminal and civil penalties as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

Maine/Ohio: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Massachusetts/Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any 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 includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

New Mexico: 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 civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

North Carolina/Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may have committed a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 subjects such person to criminal and civil penalties.

Puerto Rico: Any person who furnishes information verbally or in writing, or offers any testimony on improper or illegal actions which, due to their nature constitute fraudulent acts in the insurance business, knowing that the facts are false shall incur a felony and, upon conviction, shall be punished by a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars for each violation or by imprisonment for a fixed term of three
(3) years, or both penalties. Should aggravating circumstances be present, the fixed penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Texas: 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.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Washington/Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

2023-24
Formulario de Accidente del Estudiante
Lea las instrucciones en la página siguiente antes de completar

POR FAVOR MANDE LOS FORMULARIOS A:
CLAIMS ADMINISTRATOR
BOLLINGER SPECIALTY GROUP
P.O. Box 1346
Morristown, NJ 07962
or email:
BollingerSchoolClaims.GBS@AJG.com

1. Distrito Escolar	2. Escuela que Asiste el Niño/la Niña en el Distrito:	3. Master Policy No.:

4. Apellido del Reclamador:	Primer Nombre:	5. Fecha de nacimiento	6. ☐ Masculino ☐ Femenino	7.Telefono

8. Dirección:	9. Ciudad / Estado / Zona Postal:

10. Dirección de correo electrónico personal del padre o tutor:

11. **Marque actividad en cual participaba el estudiante cuando tuvo el accidente:**

A. ☐ Deportes Intrescolasticos _____
Nombre del Deporte

B. ☐ Animadoras ☐ Batutera o Banderetera ☐ Banda de Musica

O:

01 ☐ Clase de Educación Fisica
02 ☐ En la Clase o en el Pasillo
03 ☐ En el Patio de Recreo (pero NO durante clase de Educación Fisica
04 ☐ Yendo y Viniendo a/de la Escuela
05 ☐ Viajando en Grupo
06 ☐ Actividad Fuere de la Escuela (Plan de 24 horas)
07 ☐ Actividad Extra-Curricular (Despues de Escuela) Dentro de la Escuela
08 ☐ Actividad Extra-Curricular FUERA de la Escuela
09 ☐ Espectator

¿La Escuela estaba en sesion? ☐ **Si** ☐ **No** **Hora de Entrada:** _____ **Hora de Salida:** _____

12. Fecha del Accidente:	13. Hora: ☐ A.M. ☐ P.M.	14. ¿Cómo ocurrio el accidente?

15. ¿Donde ocurrió el accidente?	16. Parte del cuerpo herida/o:

17. Certifico que la actividad indicada arriba es patrocinda y supervisada por la escuela y que se cubre bajo una poliza que solicito y compro el dueño de dicha poliza.

Firma de Administrador (a) Escolar _____ Título: _____ Fecha _____

Dirección de correo electrónico _____ Número de teléfono _____

AUTORIZACION Y PRUEBA DE OTRO SEGURO, TIENE QUE COMPLETARLO LOS PADRES O EL GUARDIAN

AUTORIZACIONES MEDICA: Autorizo entrega de cualiquier informe medico tipo que sea necesario para procesar esta reclamacion, inclusivo de todos los datos pertinentes a esta limitación o otra incapacidad preva.	AUTORIZACIÓN DE PAGO: Autorizo pagar beneficios medicos directamente a los proveedores que prestaron servicios..
FIRMA _____ FECHA _____	FIRMA _____ FECHA _____

1. Nombre del Padre:	2. Nombre y Dirección de su Empleo:
3. Nombre de la Madre:	4. Nombre y Dirección de su Empleo:

5. ☐ NO tengo/tenemos seguro personal o de grupo de ningun tipo. La carta de mi empleo verificando que no tengo seguro medico esta uncluida.
☐ NO tengo/tenemos seguro medico soy/somos: ☐ Empleo Propio Desempleado ☐ Invalido
☐ SI, tengo/tenemos seguro personal o de grupo (Por favor complete #6).
☐ **Tenemos un plan financiado por el gobierno. (Medicaid, Tricare, etc.).** Si usted tiene seguro de enfermedad, por favor suplirnos con una copia de su tarjeta.

6. **Nombre de Otra(s) Compañia(s) de Seguro**	**Dirección**

Certifico, juro y afirmo que los informes dados aqui son verdaderos y correctos. Entiendo por completo que cualquier representación fraduienta hecha por mi con intenciones de recibir beneficios baja esta poliza constituye un fraude y puede ser castigable bajo la ley.

Firma de Madre/Padre/Guardian: _____ **Fecha** _____

PADRES: POR FAVOR LEER TODAS LAS INSTRUCCIONES ANTES DE MANDAR UN RECLAMO:

ESTE FORMULARIO DEBE DE SER MANDADO POR CORREO, CORREO ELECTRONICO O POR FAX A RPS BOLLINGER DURANTE LOS 90 DIAS DESDE QUE OCURRIO EL ACCIDENTE PARA ESTABLECER EL ARCHIVO DE SU HIJO/A.

POR CORREO A ADMINISTRACION DE RECLAMOS: Bollinger Specialty Group, PO Box 1346, Morristown, NJ 07962

POR CORREO ELECTRONICO: bollingerschoolclaims.gbs@ajg.com con el nombre de su hijo/a en la linea de tema.

POR FAX: 973-921-2876. Por favor incluir una portada con lo siguiente:

ATENCION DEPARTAMENTO DE ESCUELA DE RECLAMOS

El Seguro de accidente es comprado por la Junta de Educacion/Escuela cubre solamante en **BASES EXCESIVAS** solamente. Esto quiere decir que los gastos medicos que **NO SON** pagados por el seguro personal o grupo de seguros son elegibles en el coveraje de esta poliza. Sujeta a las limitaciones y exclusiones.

Por favor asegurese de que:

1. La escuela tiene que completer la porcion de arriba en la hoja de reclamo, incluyendo todas las preguntas hasta el numero 17. Los padres completan la parte de abajo, firmar y agregar el dia en las hoja de reclamo y luego mandar una copia a Bollinger Specialty Group.

   Una vez que allan mandado esta hoja de reclamo a Bollinger Specialty Group, empiezen a mandar todas las cuentas que an sido sometidas a su seguro personal o grupo de seguro (incluyendo su Cobertura Medica Mayor).

2. Despues de que su seguro de salud alla procesado las cuentas medicas, hacer que los proveedores, presenten facturas detalladas **(UB04 del Hospital/y CMS 1500 de todos los medicos/proveedores)** con el correspondiente Expicacion de Beneficios de su seguro primario. Por favor tenga en cuenta si usted le pago a los proveedores todos los formularios y prueba de que usted hizo los pagos de su bolsillo, por favor mandarlos par que le hagan la evolucion. **Por fabor no enviar declaraciones de balances adeudados, facturas o libros de contabilidad no detallados.**
   Si este reclamo es un **accidente dental**, el dentist debe de enviar los servicios relacionados solo en **ADA Dental formulario J430** y copias que le corresponden a la Explicacion de Beneficios de su seguro primario.

3. Despues de enviar su hoja reclamo complete y al recibir su primer **Explicacion de Beneficios** de parte de Bollinger Specialty Group, ya usted obtendra un numero de reclamo y puede visitor nuestro website **@wwwbollingerschools.com** para participar en el portal de esta linea y asi chequear el estado del reclamo de su hijo/a.

POR FAVOR NO LLAME A LA ESCUELA.

Si usted tiene preguntas de este proceso, por favor llame al numero 866-267-0092 durante las horas de 8am to 4:15pm Hora Estandar del Este de Lunes a Viernes. Si usted no puede durante las horas regulares de trabajo, por favor sientases libre de dejar un mensaje al Servicio del Cliente y se comunicaran con usted el proximo dia.

PLAN ADMINISTRACIÓN Y RECLAMO DE SERVICIO POR:

Bollinger Specialty Group
A Gallagher Company

P.O. BOX 1346, MORRISTOWN, N.J. 07962
TELEPHONE 866-267-0092
FAX 973-921-2876
www.BollingerSchools.com

Bollinger Specialty Group
A Gallagher Company

2023-2024 Plan de Seguro para Accidentes Studiantiles

Instrucciones para Hacer un Reclamo

Recorte o Muestre a su Proveedor Médico

Bollinger Specialty Group
A Gallagher Company

Student Accident
(Secondary/Excess Insurance)

Providers & Hospitals, please bill Bollinger Specialty Group directly including the name of Patient, Name of District, Diocese or Independent School and Diagnosis on all bills.

This is not a contract of insurance. The terms and conditions of coverage are set forth in the Policy issued to the school / Policyholder. The Policy is subject to the laws of the state in which it was issued.

SEND ALL FORMS TO CLAIMS ADMINISTRATOR:

Bollinger Specialty Group
PO Box 1346
Morristown, NJ 07962
or email to:

BollingerSchoolClaims.GBS@AJG.com

Questions: Please contact our Customer Service Department @ 1-866-267-0092

PREGUNTAS FRECUENTES

P. Cual es la razon de tener el seguro Secundario de accidentes?

R. Esta cobertura esta destinada para ayudar a cubrir los gastos medicos relacionados a un accidente que resulto pasar en la participacion en actividades de la escuela. La poliza paga **despues** del seguro primario que el estudiante tenga. Es asignado para cubrir gastos que no an sido pagados y serian la responsabilidad del paciente en su primer seguro Explicacion de Beneficios (EOB), como copagos, deducibles y otros tratamientos medicos, que estan sujetas a las limitaciones y exclusiones de la poliza.

P. Ademas de la hoja de reclamo, que documentos se necesitan para que el plan de seguro estudiantil procesen el reclamo?

R. El proveedor debe presentar una reclamacion de los siguientes documentos a la Administracion de Reclamo, Bollinger Specialty Group:

1). Factura medica detallada - El proveedor fracturara a la Administracion de Reclamo con un CMS 1500 o UB04 que obtendra la siguiente informacion:

- Nombre y direccion del proveedor
- Numero de Identificacion tributaria
- Dias de servicio
- Codigos de diagnostico y codigos de procedimiento
- El cobro de cada tramite

2) Explicacion principal de los Benefecios (EOB) - Esta es una declaracion de su principal compania de seguros que describe el cobro que sera cubierto o denegado y lo que cubre el seguro primero es la responsabilidad del paciente (copagos coseguro, deducible, etc.).