COLLEGE CLAIM FORM

-PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING-

SEND ALL FORMS TO CLAIMS ADMINISTRATOR:
BOLLINGER INC.
P.O. Box 1329
Morristown, NJ 07962

1. Name of College: Trocaire College				2. Master Policy No.: BOL000127	
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 FOR INSURED DEPENDENT:

11. Patient's Last Name:	First Name:	12. Date of Birth:	13. Sex: ☐ M ☐ F	14. Relationship to Student:

IF CLAIM IS FOR SICKNESS OR ROUTINE EXAM:

15. Date Symptoms First Appeared:	16. Reason for Visit:	17. Initial Treatment or Exam Date:

IF CLAIM IS DUE TO ACCIDENT OR INJURY:

18. Date of Accident or Injury: 19. Time: ☐ A.M. ☐ P.M.	20. How Did Accident or Injury Occur?
21. Where Did Accident or Injury Occur?	22. Part of Body Injured:

RE: INTERCOLLEGIATE SPORT ACCIDENT

23. If Intercollegiate Sport, Name of Sport:	24. I certify that the above named claimant was injured while participating in the practice or play of the intercollegiate sport indicated in #23.	Signature of Athletic Official:	Title: Date:
25. Athletic Official's E-mail Address:			

HEALTH CENTER REFERRAL:

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26. ☐ Date seen at Health Center _____ Authorized Signature or Initial _____

☐ I did not go to the Health Center because: (please check one)

☐ I was not in the Area ☐ It was an emergency ☐ The Health Center was closed

☐ Other _____

PAYMENT AUTHORIZATION

I hereby authorize payment of benefits directly to the providers rendering services.

Please Sign Here: _____ _____
Parent or Insured (If Adult) Date

MEDICAL AUTHORIZATION

I hereby 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 disability.

Please Sign Here: _____ _____
Parent or Insured (If Adult) Date

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 or College Official (if applicable)

COLL-15

(SEE REVERSE SIDE)

STATEMENT OF OTHER INSURANCE - MUST BE COMPLETED

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) _____

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 or sickness. Only one form is needed for each accident/sickness.

2. Subsequent bills must be submitted within 90 days of the date of service and should clearly indicate patient name, name of College or Policy Number, and Diagnosis. All bills must be itemized as claims cannot be processed from balance due statements.

3. Intercollegiate Sports Accident claims must be signed by an authorized athletic official.

4. If a Health Center Referral is required, the Health Center questions must be fully completed.

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

6. Please keep a copy of this claim form, all bills and primary insurnace Explanations of Benefits for your records.

PLAN ADMINISTRATION AND CLAIM SERVICE BY:

Bollinger Specialty Group
BOLLINGER, INC., A SUBSIDIARY OF
ARTHUR J. GALLAGHER & CO.

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