



Hopatcong Borough Schools

Dr. Joseph S. Piccirillo
Superintendent of Schools

Learning Today. Leading Tomorrow.

September 1, 2022

Dear Parent/Guardian:

Please note that the Hopatcong Borough School District does not hold student accident insurance for your child(ren). If your child becomes injured while on school property, all medical bills must be submitted to your own insurance carrier.

A Voluntary Participation Student Accident Insurance Plan is again being made available to all students at a reasonable cost. This plan is administered by Bollinger Insurance. For program information regarding benefits under the various plans offered, in addition to the standard "School-Time" student accident insurance, please log onto the Bollinger website at: <http://www.bollingerschools.com> or access via the link on our website www.hopatcongschools.org under the Parents & Students tab on our homepage.

If you plan to purchase one of the coverages offered, there are several options available to you:

1. Buy Online.
2. Download application and mail check to **Bollinger Inc., P.O. Box 1515, Morristown, NJ 07962**. (Your cancelled check is your receipt.)
3. Receive an application by mail.

NOTE: If you purchase insurance during the enrollment period, coverage for school-time accidents will be retroactive to the beginning of the school year.

PROCEDURE IN EVENT OF CLAIM

As soon as possible after your child sustains an injury/accident, download a Bollinger claim form from the website listed above. Read the instructions carefully. Present the form to the school nurse for completion of questions 1 - 17, complete & sign the remainder of the form and submit to Bollinger within 90 days of the incident:

Claims Administrator
Bollinger Specialty Group
P.O. Box 1346
Morristown, NJ 07962

Telephone number: 1 866-267-0092

The completed claim form must be submitted to the insurance company within the **ninety (90) days' time limit** from the date of the accident, as stated within the policy, even though further treatment is necessary.

It is the parent's responsibility to see that the accident claim form is processed by the doctor handling the treatment or injury. The school has no control over the processing of claims, nor the amount of benefits paid by the insurance company. All inquiries should be directed to the Bollinger Insurance Company.

Please see the attached flyer for additional information.

Very truly yours,

Dr. Joseph S. Piccirillo
Superintendent of Schools



K-12 Voluntary Student Accident Insurance

AVAILABLE COVERAGE OPTIONS

Depending on which program your school provides, some or all of the following voluntary insurance products are available for purchase on a voluntary basis:

- School time only student accident insurance
- 24-hour accident coverage
- Student dental accident insurance

KIDS WILL BE KIDS

1. Make sure your child is properly covered against unforeseen accidents.
2. Purchase coverage at your convenience from any computer.
3. Follow the easy step-by-step instructions and you're done in minutes!



These voluntary participation student accident insurance plans offered through your school can be purchased easily online at:

www.BollingerSchools.com

OFFICE LOCATION

200 Jefferson Park, Whippany, NJ 07981

BollingerSchools.com



The information contained herein is offered as insurance industry guidance and provided as an overview of current market risks and available coverages and is intended for discussion purposes only. This publication is not intended to offer legal advice or client-specific risk management advice. Any description of insurance coverages is not meant to interpret specific coverages that your company may already have in place or that may be generally available. General insurance descriptions contained herein do not include complete insurance policy definitions, terms and/or conditions, and should not be relied on for coverage interpretation. Actual insurance policies must always be consulted for full coverage details and analysis. DBA Risk Placement Services Insurance Brokers. CA License No. 0C66724. Copyright © 2020 Risk Placement Services, Inc.

2022-23

Student Accident Claim Form

**Please Read Instructions On The Next
Page Before Completing**

**SEND ALL FORMS TO
CLAIMS ADMINISTRATOR:
RPS Bollinger
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. <input type="checkbox"/> Male <input type="checkbox"/> Female
7. Telephone:		
8. Home Address:	9. City/State/Zip Code:	
10. Personal Email Address of Parent or Guardian:		

11. 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 04 ☐ To and From School 07 ☐ Extra Curr. Activity ON Premises
- 02 ☐ Classroom or Hallway 05 ☐ Group Travel 08 ☐ Extra Curr. Activity OFF Premises
- 03 ☐ Playground (NOT Phys. Ed.) 06 ☐ Non-School Activity (24 Hr. Plan) 09 ☐ Spectator

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

12. Date of Accident:	13. Time: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	14. How Did Accident Occur?
15. Where Did Accident Occur?		16. Part of Body Injured:

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

1. Father's Name:	2. Name and Address of His Employer:
3. Mother's Name:	4. Name and Address of Her 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:

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 up to the limits.

Please follow these instructions below when filing a claim:

1. THIS CLAIM FORM MUST BE MAILED TO BOLLINGER WITHIN 90 DAYS OF THE DATE OF ACCIDENT TO ESTABLISH YOUR CHILD'S CLAIM FILE.

Please be sure that:

- a) The school official has completed his/her section of the claim form.
 - b) You have completed and signed the Parent's Statement and Medical Authorization.
 - c) The Statement of Other Insurance section must be fully completed.
2. Once you have sent 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).
3. 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. Documents should be mailed to the PO Box shown below.

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

4. Please write the claimant's name, policy number, and date of accident on all Bills and Explanation of Benefits.
5. Please keep a copy of this Claim Form, all bills, and primary insurance Explanation of Benefits for your own records.
6. 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.BollingerSchools.com
PLEASE DO NOT CALL THE SCHOOL.

7. 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.BollingerSchools.com to enroll and check the status of your claim online.

PLAN ADMINISTRATION AND CLAIM SERVICE BY:



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

www.BollingerSchools.com

Fraud Warnings Disclosure

Any person who knowingly and with intent to defraud any insurance company or another 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 may subject the person to criminal and civil penalties. (Not applicable in AL, AR, CO, DC, FL, KS, KY, LA, MD, ME, NJ, NM, NY, OH, OK, OR, PA, PR, RI, TN, TX, VA, VT, WA, and WV.)

In Arkansas, Louisiana, Rhode Island, or 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.

In 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.

In 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.

In District of Columbia: Warning: 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.

In 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.

In Kansas: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to an insurer, purported insurer, or to or by a broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act and may be subject to criminal and/or civil fines or penalties.

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

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

In **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.

In **New Jersey**: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

In **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.

In **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.

In **Ohio**: Any person who, with 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 is guilty of insurance fraud.

In **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.

In **Oregon**: Any person who knowingly and with intent to defraud any insurer or other person files an application for insurance or statement of claim containing any materially false information upon which an insurer relies, if such information was either material to the risk assumed by the insurer or the misinformation was provided fraudulently, may commit a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

In **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.

In **Puerto Rico**: Any person who has committed fraud, as defined in the law, shall incur a felony, and if convicted, shall be sanctioned for each violation by a penalty of a fine of not less than five thousand dollars (\$5,000), nor more than ten thousand dollars (\$10,000), or a penalty of imprisonment for a fixed term of three (3) years, or both penalties. If there were aggravating circumstances, the fixed penalty thus established may be increased up to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years. In addition to the penalties provided in this chapter, any person who, as a result of the fraud thus committed is benefited in any way to obtain insurance, or in the payment of a loss pursuant to an insurance contract, shall be imposed the payment of restitution of the amount of money resulting from the fraud. Every violation shall have a prescription term of (5) five years.

In **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.

In **Vermont**: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.