August, 2011

TO: Parents/Guardians

FROM: Stacy M. Gober, Assistant to the Superintendent for Finance and Administration

SUBJECT: BASD STUDENT ACCIDENT INSURANCE – HOW IT WORKS.

Participants in elementary school, middle school, high school athletic sports programs, intramural sports programs as well as gym classes, recess, band, and cheerleading are covered by an accident insurance program approved by the Board of School Directors. This coverage **IS NOT** intended to replace the Major Medical coverage provided by parents or guardians through group insurance on their plans.

Under the Bethlehem Area School District's insurance program, the first $100.00 of expenses for injuries will be paid regardless of other insurance. **At this point, the participant's own coverage will take over**. Other expenses, beyond that covered by the family's insurance, will be covered according to the schedule of payments as outlined by the school district's insurance company.

It is our desire to provide to each parent or guardian a description of the coverage and procedures. The policy provided does have limited coverage. Under no circumstances should it be concluded, and is definitely not meant to be implied to student athletes, parents, or guardians, that there is 100% coverage in the event of all injuries. Benefits under the Bethlehem Area School District's plan are, in most instances, the "Usual and Customary Fee" for necessary treatment, up to the policy's limits as listed on the reverse side of this letter – two (2) year benefit payment period.

RETURNING FORMS:

CLAIM FORMS **MUST BE MAILED TO BOLLINGER** WITHIN **90 DAYS** OF THE DATE OF ACCIDENT.
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 Authorizations.
c) You have attached itemized bills to the form.
d) The statement of Other Insurance section of the form must be completed.

MAIL TO: Claims Administrator
Bollinger Inc.
P.O. Box 706
Short Hills, NJ 07078-0706

Please keep a copy of the Claim Form, all bills and primary insurance Explanations of Benefits for your own records.

If you need further information call 866-267-0092 or contact Bollinger Insurance at www.bollingerschools.com

Thank you for your cooperation in this matter.

SMG:acv

cc: Dr. Joseph J. Roy, Superintendent of Schools
Dr. Dean M. Donaher, Director of Student Services
Fred Harris, Athletic Director
Lorie Olexson, Athletic Secretary
Charisse Pfeiffer, Athletic Secretary
Elementary & Secondary Building Administrators
Elementary & Secondary School Nurses
Intramural Supervisors

INSURANCE COVERAGE 2011-12
PRIMARY EXCESS OVER $100

SUMMARY OF BENEFITS

PLAN MAXIMUM---$1,000,000.00

HOSPITAL:

Room & Board - Semi-Private --Usual & Customary
Room & Board - Intensive Care--Usual & Customary
Miscellaneous Services---Usual & Customary
Emergency Room - Out Patient ---Usual & Customary

DOCTOR'S SERVICES:

Surgery - Including Pre & Post Operative Care ---------------------------------Usual & Customary
Anesthesia---Usual & Customary
Doctor's Visits (non-physiotherapy)--Usual & Customary
Consultation & Second Opinion
When required by Attending Physician --Usual & Customary

Lab & X-ray--Usual & Customary

OTHER SERVICES:

Physiotherapy (In Hospital) ---Usual & Customary
Physiotherapy (Out Of Hospital) --Usual & Customary
--Usual & Customary
Registered or Licensed Nurse
(When prescribed by doctor)--Usual & Customary
Ambulance - to initial treatment facility ---Usual & Customary
Out-Patient Prescriptions - prescribed by Doctor --------------------------------Usual & Customary
Eyeglasses/Contact/Hearing Aids*
*Replacement when broken due to covered
injury requiring medical or surgical treatment ----------------------------------Usual & Customary

DENTAL:

Treatment, repair or replacement of each injured
natural tooth. ---$10,000.00 Maximum

Note: The information illustrated above is subject to all policy provisions.

-PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING-

SEND ALL FORMS TO CLAIMS ADMINISTRATOR:
BOLLINGER INC.
P.O. Box 706
Short Hills, NJ 07078-0706

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

4. Claimant's Last Name: First Name:	5. Date of Birth:	6. ☐ Male ☐ Female	7. Telephone:

8. Home Address:	9. City/State/Zip Code:

10. E-mail 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: ☐ A.M. ☐ 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 ________

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. 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.

6. ☐ Yes, we do have other insurance. (Please complete #7).

7. **Names of other Insurance Companies**	**Address**

8. ☐ We have no other insurance. We are (please check one): ☐ Self-employed ☐ Unemployed ☐ Disabled

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** ____________

CLF-PA-100X-11

The accident insurance coverage purchased provides coverage on an **EXCESS** basis. Under this plan, the first $100 of covered charges are paid without regard to any other applicable coverage that may be in effect. After the first $100 in covered charges are paid, expenses which are **NOT** covered by your other personal or group insurance are eligible for coverage under this plan up to the policy limit.

Please follow these instructions when filing a claim:

1. **CLAIM FORMS MUST BE MAILED TO BOLLINGER WITHIN 90 DAYS OF THE DATE OF ACCIDENT.** 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 Authorizations.
   c) You have attached itemized bills to this form.
   d) The statement of Other Insurance section of the form must be completed.

2. If the claim totals more that $100, we will pay the first $100 and return the expenses to you for submission to your own personal or group insurance coverage.

3. If you have coverage through an HMO (or similar organization) you must comply with their requirements once the first $100 has been paid, or your remaining balances will not be covered under this policy.

4. After your own insurance has paid the medical expenses, attach the itemized bills (CMS-1500 from physicians and UB-04 from hospitals) and copies of the Explanation of Benefits from your primary insurance company to this claim form and mail to the address shown below. **We cannot accept balance due bills.**

5. The subsequent bills and Explanation of Benefits from your other insurance should be sent in as you receive them. Please write the claimant's name, policy number and date of accident on all subsequent bills. **A new claim form is not necessary.**

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

If you need further information call 866-267-0092 or contact us on our website at www.BollingerSchools.com
DO NOT CALL THE SCHOOL.

Than you for your cooperation.

PLAN ADMINISTRATION AND CLAIM SERVICE BY:

P.O. BOX 706, SHORT HILLS, N.J. 07078-0706 • TELEPHONE (866) 267-0092

www.BollingerSchools.com