

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

**-PLEASE READ INSTRUCTIONS ON THE NEXT PAGE  
BEFORE COMPLETING-**

|                               |             |                 |                      |  |  |  |
|-------------------------------|-------------|-----------------|----------------------|--|--|--|
| 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:<br><input type="checkbox"/> M <input type="checkbox"/> F | 7. Marital Status<br><input type="checkbox"/> M <input type="checkbox"/> 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:<br><input type="checkbox"/> A.M.<br><input type="checkbox"/> 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.<br><br>SIGNED _____ DATE _____ | PAYMENT AUTHORIZATION: I authorize payment of medical benefits directly to the providers rendering services.<br><br>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. <input type="checkbox"/> 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](http://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](http://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



## 2023-2024 College Student Accident Insurance Claims Filing Instructions

Louisiana State University Health Sciences Center at Shreveport has obtained a policy to provide insurance protection to students injured while participating in school sponsored and supervised activities. Coverage is secondary to other coverage that may be in force for the student.

### CLAIMS FILING INSTRUCTIONS

To avoid processing delays, please follow all instructions:

1. The student (not the Doctor or Hospital) should submit a fully completed claim form within 90 days of an injury.
  - a. Only one form is needed for each accident.
  - b. Claim forms are available at [www.BollingerColleges.com](http://www.BollingerColleges.com).
  - c. The Statement of Other Insurance must be completed.
2. If there is Other Insurance in effect, bills should first be sent to that insurance carrier.
3. Bills should also be submitted to RPS Bollinger within 90 days of the date of service and should clearly indicate patient name, name of College, and Diagnosis. All bills must be itemized as claims cannot be processed from balance due statements.
4. Explanation of Benefits showing what was paid by the Other Insurance should also be submitted to Bollinger Specialty Group.
5. Please keep a copy of this claim form, bills and primary insurance Explanations of Benefits for your records.

### Cut out or Show Your Medical Provider

|  |  |   |  |
|--|--|---|--|
|  | Louisiana State University Health<br>Sciences Center at Shreveport | *<br>*<br>*<br>*<br>*<br>*<br>*<br>*<br>*<br>*<br>* | <b>SEND ALL FORMS TO<br/>CLAIMS ADMINISTRATOR:</b>   |
|  | <b>Student Accident<br/>Secondary/Excess<br/>Insurance</b>         |   | <b>Bollinger Specialty Group<br/>PO Box 1329<br/>Morristown, NJ 07962</b>                                  |
|  | Policy Effective: 8/15/23<br>Deductible: \$0<br>Maximum: \$10,000  |   | or email to:<br><a href="mailto:BollingerCollegeClaims.GBS@AJG.com">BollingerCollegeClaims.GBS@AJG.com</a> |
|  |  |   | <b>Claims: 1-866-267-0092<br/>Other Inquiries: 1-800-526-1379</b>  |

### Bollinger Specialty Group

A Gallagher Company

# 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. The Secondary Accident Insurance 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.

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 **HCFA 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.).

Q. How long is a student covered under the school's policy?

A. The policy has a **90 day** benefit period from the date of a covered injury.

## ***For Additional Questions Please Contact:***

**Bollinger Specialty Group**  
PO Box 1329  
Morristown, NJ 07962

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**Email: [BollingerCollegeClaims.GBS@AJG.com](mailto:BollingerCollegeClaims.GBS@AJG.com)**

*This is a brief description of the important features of the insurance plan. It 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.*

**Bollinger Specialty Group**

A Gallagher Company

[www.BollingerColleges.com](http://www.BollingerColleges.com)

## 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.