Willis Towers Watson

Dear Parents,

We are pleased to provide a Student Accident Insurance Program to protect you children in the event of an accident which is unexpected event during school activities as defined below:

School Coverage:

1. While in or on school grounds or premises during a period of regular attendance during the days and months when school ls in session.
2. While traveling directly and without delay to or from the covered persons residence and school for regular classroom sessions, for such travel time as may be necessary, within one hour of school begins and one hour after dismissal from school, or longer If a school bus requires;
3. While participating in or attending school sponsored activities and directly and continually supervise by a school official or employee subject to the limitations of the policy. This includes supervised travel by school furnished transportation, directly and uninterruptedly from school sponsored activities; and
4. While attending religious classes on or away from the schools premises, including travel to or from the covered person's residence or school and the place where such classes are held.

Sports Coverage:

1. We will pay the benefits described In the policy for an accident which occurs while a covered person is;
    a. A regularly scheduled athletic game or competition
    b. A practice session for an athletic team or club;

2. Traveling to or from such a game, competition or practice session provided he/she is;
    a. Traveling with the athletic team or club; and
    b. Under the direct and Immediately supervision

3. Traveling directly, without interruption;
    a. Between his/her home for a scheduled game, competition or practice session
    b. In a vehicle which Is operated by a properly licensed driver

Please note there is a **30 day reporting time frame**, you must fill out the form provided by your school administration. The form must be sent to the contacts listed below. If you should have any questions or concerns, please do not hesitate to contact BMI Benefits or Kenia Ortez directly.

Sincerely,

Administration

BMI Benefits
Direct Line: 800.445.3126
clerk@bobmccloskey.com

Kenia Ortez
Willis Towers Watson
Client Manager
Direct Line: 305.421.6251
Kenia.Ortez@Willistowerswatson.com

Maria Dewar-Woolcock
Willis Towers Watson
Senior Client Manager
Direct Line: 786.389.5173
Maria.Dewar-Woolcock@Willistowerswatson.com

Group of Charter Schools

Blanket Accident Policy

Policy Number KSA L004009030208

Standard Operating Procedures when a student is injured

1. Attached please find Claims ID Cards. These should be provided to Doctor or Hospital for direct billing.

2. The attached Claim Form must be completed by parent/guardian within 30 days of injury

3. Must provide itemized bill (1500 Form or UB Form) and the explanation of benefits (EOB) statement from primary insurance carrier.

4. Email Completed Form to:
   BMI Benefits, LLC
   Email: clerk@bobmccloskey.com
   Subject Line: Child Last Name / Date of Birth (this will become their claim #)

   Copy to: Kenia.Ortez@Willistowerswatson.com
   Maria.Dewar-Woolcock@Willistowerswatson.com

BMI Benefits
Direct Line: 800.445.3126
clerk@bobmccloskey.com

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Willis Towers Watson
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Direct Line: 305.421.6251
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HOW TO FILE A CLAIM:

1. Complete this form within 90 days.
2. Attach Itemized Bills and Primary Carrier Statements
3. Mail to: BMI Benefits, LLC, P.O. Box 511, Matawan, NJ 07747 800-445-3126 (P) 732-583-9610 (F)

BMI Benefits, LLC. Accident Claim Form

Got You Covered

ANY PERSON WHO KNOWINGLY AND/OR WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY OR OTHER PERSONS FILES A STATEMENT OF CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION, MAY BE GUILTY OF INSURANCE FRAUD AND SUBJECT TO CRIMINAL AND SUBSTANTIAL CIVIL PENALTIES.

This part must be completed and signed by an official of the policyholder or the claim cannot be processed

PART 1A: POLICYHOLDER

School/Organization: Group of Charters Schools

Policy#: KSA L004009030208

School Mailing Address

City, State, Zip

Injured Person's Name

Birth date

Male ☐ Female ☐

Date of Injury Time Type of Sport/Activity Part of body injured

How did Injury occur?

Sport Designation: Interscholastic ☐ Classroom ☐ PE Class ☐ Recess ☐ Other ☐

At the time of the injury, was the injured involved in an activity sponsored and supervised by the policy holder? YES ☐ NO ☐

Name of Supervisor Was he/she a witness to the accident? YES ☐ NO ☐

Signature of Supervisor/Official Title Date

PART 1 B: INJURED PERSON'S INFORMATION

THE INJURED PERSON'S SOCIAL SECURITY NUMBER MUST BE PROVIDED AS REQUIRED BY THE CENTER FOR MEDICARE SERVICES

Injured Person's Social Security Number

Injured Person's Home Address (Street, City, State, Zip)

Is the injured Person Employed? YES ☐ NO ☐ If yes, please fill out Section A below.

Is the injured Person Married? YES ☐ NO ☐ Spouse's Name

Is the Spouse Employed? YES ☐ NO ☐ If yes, please fill out Section B below.

Are you covered by any other insurance policy, either as a dependent, group, individual, automobile medical or liability YES ☐ NO ☐

If Yes: Name of Insurance Carrier _____ Policy #: _____

PARENT/GUARDIAN INFORMATION

Father/Guardian Name	Mother/Guardian Name
Address (Street, City, State, Zip)	Address (Street, City, State, Zip)
Home Phone	Home Phone
Is the Father Employed? YES ☐ NO ☐	Is the Mother Employed? YES ☐ NO ☐

SECTION A (INSURED/FATHER)	SECTION B (SPOUSE/MOTHER)
Employer	Employer
Address (Street, City, State, Zip)	Address (Street, City, State, Zip)
Business Phone	Business Phone
Insurance Company Policy#	Insurance Company Policy#

MEDICAL INFORMATION AUTHORIZATION ASSIGNMENT OF BENEFITS:

You are hereby authorized to furnish at the request of and to BMI Benefits, LLC or the underwriting companies with which it works, information which you may possess; including findings and treatment rendered, X-rays and copies of all hospital and medical records, all occasioned by professional services and hospital care rendered on my behalf. The foregoing authorization is granted with the understanding that any legal rights I may ordinarily have to claim communications between us as privileged are hereby expressly and voluntarily waived. A Photostat of this authorization shall be considered as effective and valid as the original, PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

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

Claimant or Authorized Person's Signature Date

Willis Towers Watson

Group of Charter Schools
Student Accident Policy

Claim #: ____________________________________

(Child Last Name/DOB)

(Must be included in all correspondence for claim processing)

Carrier: Berkley Life and Health Insurance Company
Policy#: KSA L004009030208
Email: clerk@bobmccloskey.com
Phone: 1-800-445-3126
Billing Address: PO Box 511, Matawan, NJ 07747

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