STUDENT ACCIDENT CLAIM FORM

HOW TO FILE YOUR CLAIM

1. Complete this form within 90 days.
2. Attach itemized bills.
3. Mail to: BMI Benefits
   P. O. Box 511
   Matawan, NJ 07747
   Phone Number: 1-800-445-3126

MARKEL INSURANCE COMPANY

FLORIDA REQUIRED STATEMENT - Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing false, incomplete or misleading information is guilty of a felony of the third degree.

PART 1: SCHOOL

School or District Name: _____ Policy No.: _____

Address: _____
(Street) (City) (State) (Zip)

Claimant's Name: _____ Date of Birth: _____ ☐ Male or ☐ Female
MM DD YY

Date of Injury: _____ Time: _____ ☐ AM ☐ PM Grade: _____
MM DD YY

Where did injury occur? _____

How did injury occur? _____

Nature of Injury: _____

If athletics, please name the sport: _____ What type: ☐ Intramural ☐ Interscholastic ☐ Other: _____

On date of injury, what time did school start for this student? _____ What time was student dismissed from school? _____

At the time of injury, was the claimant involved in any activity under the jurisdiction of the Policyholder? ☐ Yes ☐ No

Under whose supervision? _____ Was he/she a witness? _____

Signature: x _____ Title _____ Date _____

(Must be signed by a school official if the accident was school related)

PART 2: Claimant's Section

Provide both ***claimant*** and ***parent*** information

Claimant Information

Claimant's Social Security Number _____ Phone Number (___) _____

Claimant's Street Address _____ City _____ State _____ Zip _____

Parent Information

Claimant's Father's Name _____ Social Security Number _____

Father's Employer _____

Street Address _____ City _____ State _____ Zip _____

Claimant's Mother's Name _____ Social Security Number _____

Mother's Employer _____

Street Address _____ City _____ State _____ Zip _____

Please list ALL OTHER insurance policies:

Name of Other Insurer: _____ ☐ No Other Insurance

Address: _____ ☐ Group _____ Policy No. _____

Phone # _____ ☐ Individual _____ Policy No. _____

Name of Other Insurer: _____ ☐ Other _____ Policy No. _____
Address: _____

Phone # _____

AUTHORIZATION FOR RELEASE OF INFORMATION: I AUTHORIZE any physician, medical care provider, hospital, clinic, medical care facility, insurance company, government-sponsored health plan, or employer having information available as to diagnosis, treatment and prognosis with respect to any illness, injury, physical or mental condition, and/or treatment for me or my minor children now or in the past, to give to Markel Insurance Company (MIC) or its legal representative, any and all such information.
I UNDERSTAND the information obtained by the use of the Authorization will be used by MIC to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by MIC to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize.
KNOW that I may request to receive a copy of this Authorization.
AGREE that a photographic copy of this Authorization shall be as valid as the original. I also AGREE this Authorization shall be valid for a period of two years from the date shown below. I may revoke this authorization at any time by written request to MIC.
CERTIFY that the information given by me in support of this claim is true and correct

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.

AFFIDAVIT: I verify that the statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim, I will reimburse Markel Insurance Company to the extent for which Markel Insurance Company would not have been liable.

Claimant, Parent or Authorized Representative's Signature: _____ **Date** _____
If Authorized Representative, Relationship to Patient or Legal Designation: _____

ITEMIZED BILLS FOR MEDICAL EXPENSES MUST BE ATTACHED

IF DENTISTRY, ANSWER ALL QUESTIONS BELOW, IN ADDITION TO THOSE ABOVE.

1. State exactly which teeth were involved in the accident and indicate them on the chart:

   _____

   _____

2. Describe exact nature of injury:

   _____

   _____

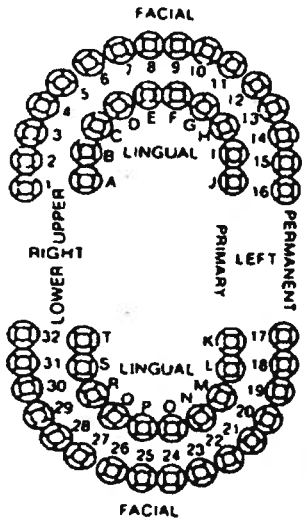
3. Describe condition of injured teeth prior to accident:
   ☐ Whole, sound and natural ☐ Filled ☐ Capped ☐ Artificial
4. Comments:

   _____

   _____

   _____

   _____



SIGNED: _____ DEGREE: _____ DATE: _____
PRINT NAME: _____
I.D. OR S.S. NO. _____ (THIS MUST BE INCLUDED) PHONE NO. (____) _____

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

IMPORTANT: This form must be completed and returned WITHIN 90 DAYS from the date of treatment, accompanied by all bills incurred to that date.