Estimados Padres,

Estamos muy contentos de ofrecer un programa de seguro de accidente estudiantil para proteger a sus hijos en caso de accidentes inesperados durante las actividades escolares, como se define abajo:

Cobertura Escolar:

1. Mientras que estén en la escuela durante su período de asistencia regular durante los días y meses cuando la escuela este en sesión.
2. Mientras que viajen directamente hacia o desde la residencia del estudiante, durante las horas de colegio regular. Por el tiempo de viaje que sea necesario, dentro de una hora antes del comienzo de escuela y una hora después de salida de la escuela o más tiempo si el viaje es en un autobús escolar;
3. Mientras que participen o asistan en actividades que la escuela patrocine y sean supervisadas directa y continuamente por un oficial de la escuela o empleado, sujeto a las limitaciones de la póliza. Esto incluye viajes supervisados por transporte escolar, directamente y sin interrupción de actividades patrocinadas por la escuela;
4. Mientras asistan a clases de religión, en la escuela o estando fuera de las instalaciones de la misma, incluyendo viajes a o desde la residencia de la persona cubierta o desde la escuela y el lugar donde se realizan estas clases.

Cobertura de Deportes:

1. Pagamos los beneficios descritos en la póliza por un accidente que ocurra mientras que la persona cubierta este;
    a. En un juego atlético, regulares o competencia
    b. Una sesión de práctica para un equipo deportivo o club;
2. Viajar a o desde un juego de competencias o sesión de práctica siempre que sea;
    a. Viajando con el equipo deportivo o club;
    b. Bajo la directa e inmediata supervisión de la escuela
3. Viajando directamente, sin interrupción;
    a. Desde su casa para una sesión de juego, competencia o prácticas programada
    b. O en un vehículo que es operado por un conductor debidamente autorizado

Por favor note que hay un plazo de ***30 días*** para reportar un accidente. Debe llenar el formulario proporcionado por la administración de la escuela. El formulario debe ser enviado a los contactos que aparecen en la portada.

Si usted tiene cualquier pregunta no dude en contactar a BMI o Kenia Ortez directamente, su contacto se encuentra abajo.

Atentamente,

La Administración

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

Número de Póliza: KSA L004009030208

Reglas de Procedimiento en caso de un Accidente

1. Adjunto encuentre tarjeta de identificación que debe proveer al Doctor u Hospital para que manden las facturas directamente a BMI.

2. El formulario de reclamación adjunto debe ser completado por un padre dentro de 30 días del accidente.

3. Fije un proyecto de ley (formulario 1500 o formulario UB04) y la declaración de beneficios (*explanation of benefits* - EOB) de su seguro primario (si corresponde)

4. Mande el formulario completo por Email a:

   BMI Benefits, LLC
   Email: clerk@bobmccloskey.com
   Sujeto: Apellido / Fecha de Nacimiento del estudiante (este será el número de reclamo)

   Copia a: Kenia.Ortez@Willistowerswatson.com
   Maria.Dewar-Woolcock@Willistowerswatson.com

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Direct Line: 800.445.3126
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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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