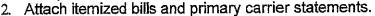
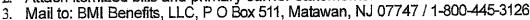
HOW TO FILE YOUR CLAIM:

Claimant or Authorized Person's Signature

Complete this form within 90 days







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

PART 1A: POLICYHOLDER This part must be completed and signed by an official of the policyholder or the claim cannot be processed. School/Organization Haverhill High School Policy# PAI L00490140 002 Address 137 Monument St. Haverhill, MA 01832 Male Female Date of Birth Injured Person's Name Injury Date: Time: Type of Sport or Activity: Intramural Interscholastic Other Where and how did accident occur? (Be specific-identify part of body and nature of injury.) At the time of injury, was the injured involved in an activity sponsored and supervised by the policyholder? YES___ Name of Supervisor ______ Was he/she a witness to the accident? YES ___NO ____ Signature of Supervisor/Official ______ Title _____ Date _____ PART 1B: INSURED INFORMATION THIS PORTION MUST BE FILLED OUT COMPLETELY BEFORE CLAIMS CAN BE PROCESSED Injured Person's Social Security Number_____ Injured Person's Home Address Cell Phone: City/State/Zip Home Phone: Is the injured person employed? Y/N If yes, please fill out Section A below. Spouse's Name: Is the injured person married? Y/N ___ Is the spouse employed? Y/N _____ If yes, please fill out Section B below. Parent/Guardian Information Mother/Guardian Name Father/Guardian Name Address Address City/State/Zip City/State/Zip Home Phone: Home Phone: Is mother employed? Y/N __ If yes, fill out section B. Is father employed? Y/N If yes, fill out section A. SECTION B (SPOUSE/MOTHER) SECTION A (INSURED/FATHER) Employer Employer: Address Address __ City/State/Zip City/State/Zip Phone Phone Insurance Company Insurance Company Policv# Policy # __ MEDICAL INFORMATION AUTHORIZATION ASSIGNMENT OF BENEFITS: You are hereby authorized to furnish at the request of and to BMI Benefits, LLC-or their representatives information which you may possess; including findings and treatment rendered, X-rays and copies of all hospital or 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.