

**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

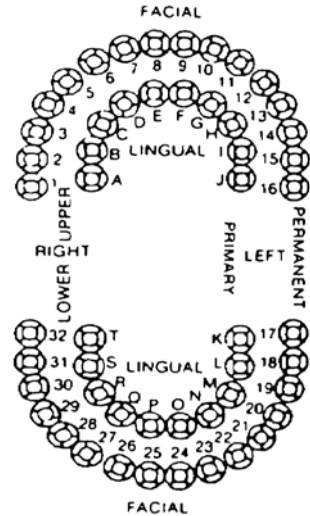
4. Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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.**