# WEST MILFORD PUBLIC SCHOOLS

*46 Highlander Drive, West Milford, New Jersey 07480*
*Phone: 973-697-1700 www.wmtps.org Fax: 973-697-8351*

**Alex Anemone, Ed.D.**
**Superintendent**

**Barbara Francisco**
**Business Administrator/Board Secretary**

**Daniel Novak**
**Director of Education**

**Elizabeth McQuaid, OTD**
**Director of Special Services**


August 1, 2017

Dear Parents/Guardians:

The West Milford Board of Education has purchased **Student and Athletic Accident Insurance** coverage for the **2017-2018** school year, to protect all students against accidental injury during all school sponsored and supervised activities, including interscholastic sports. This coverage is administered through **Bob McCloskey Insurance**, Matawan, New Jersey, and is underwritten by U.S. Fire Insurance Company.

This insurance plan is **EXCESS** coverage, meaning that you must submit all bills to your own insurance carrier first. The school policy will then process all unpaid balances up to the limits of the policy. Although this coverage is very broad, there are restrictions, limitations and exclusions in this policy.

In some situations, medical bills may not be covered in full. Parents/guardians should understand that submitting medical expenses are their own responsibility, and not that of the schools. With additional medical coverage for all students added to the Gold Plan, some of the important benefits and limitations of the plan are:

1. Maximum medical benefit is $5,000,000. Benefits are payable for up to 10 years from the date of injury.
2. Treatment **must commence within 90 days** of the date of injury, or there is no coverage.
3. Physical Therapy treatment (including Chiropractic) has a limit of $10,000. (A letter of Medical Necessity is required).

All injuries should be immediately reported to a coach, nurse or faculty member. Claim forms will be provided by the school, but it is the parents/guardians' responsibility to:

1. Submit claim form with Part 1B filled out completely (any omissions will delay processing of the claim).
2. Submit all itemized bills (monthly statements will not be accepted).

Submit the statement (EOB – Explanation of Benefits) received from your own insurance carrier showing amounts paid and balances due, or a letter of denial stating the claim is not covered. **One of these items is required for any payments to be made on the claim**. If you have no other medical insurance, you will receive a letter from the insurance company requesting employer information. Please fill out this information and return it to the carrier immediately so that the claim can be processed. Failure to return this letter will result in a delay or denial of the claim.

It is your responsibility and to your benefit to submit the necessary forms as soon as possible, as a claim cannot be paid until all paperwork is submitted. Only one claim form per accident is required. All claim forms, bills and letters from other insurance carriers are to be sent to: BMI Benefits, LLC, P.O. Box 511, Matawan, New Jersey 07747. Any questions regarding coverage can be answered by calling toll free at 1-800-445-3126.

If you should require additional assistance, please contact the Board of Education Business Office at 973-697-1700, extension 5052.

**OPTIONAL ADDITIONAL INSURANCE:**

If you wish to purchase 24-hour Accidental Medical Insurance coverage, please refer to the attached brochure accompanying this letter. Around The Clock – 24 Hour Accident Coverage with a $500,000 maximum benefit, and a 24-hour Extended Dental Insurance with a $50,000 maximum benefit, are both available for purchase at an additional cost. Participation in one or both of these plans is strictly optional.

You may access this with relative ease from any computer or iPad via the following on-line address: www.bobmccloskey.com. Just follow the instructions and you can purchase your optional coverage in minutes. Should you have any questions, please call **1-800-445-3126** and a representative at **Bob McCloskey Insurance** will be happy to assist you with the process.

Sincerely,

Barbara Francisco

Barbara Francisco
Business Administrator/Board Secretary

BF:jc
Attachments

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HOW TO FILE YOUR 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 / 1-800-445-3126

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

## PART 1A: POLICYHOLDER

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

School/Organization _____ Policy# _____

Address _____

Injured Person's Name_____ Male___ Female___ Date of Birth_____

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____ NO____

Name of Supervisor _____ Was he/she a witness to the accident? YES____NO____

Signature of Supervisor/Official _____ Title _____ Date_____

## PART 1B: INJURED PERSON'S INFORMATION

*THE INJURED PERSON'S SS# MUST BE PROVIDED AS REQUIRED BY THE CENTER FOR MEDICARE SERVICES.*

Injured Person's Social Security Number_____

Injured Person's Home Address_____

City/State/Zip _____Home Phone: _____Cell Phone: _____

Is the injured person employed? Y/N ____ If yes, please fill out Section A below.

Is the injured person married? Y/N _____ Spouse's Name: _____

Is the spouse employed? Y/N _____ If yes, please fill out Section B below.

## Parent/Guardian Information

Father/Guardian Name_____ Mother/Guardian Name _____

Address _____ Address _____

City/State/Zip _____ City/State/Zip _____

Home Phone: _____ Home Phone: _____

Is father employed? Y/N __ If yes, fill out section A. Is mother employed? Y/N __ If yes, fill out section B.

### SECTION A (INSURED/FATHER)

Employer: _____

Address _____

City/State/Zip _____

Phone _____

Insurance Company _____

Policy # _____

### SECTION B (SPOUSE/MOTHER)

Employer _____

Address _____

City/State/Zip _____

Phone _____

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

# *Claim Form Fraud Statement*

**FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED:**
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**ARIZONA:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**CALIFORNIA:** For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**COLORADO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

**FLORIDA: WARNING:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**NEW HAMPSHIRE:** Any person who with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**NEW JERSEY:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**VIRGINIA:** Please **NOTE** that these fraud warnings **DO NOT** apply in the State of Virginia.

| BENEFIT | GOLD PLAN | SILVER PLAN | |
|---|---|---|---|
| | | **Voluntary** | **Sports & Compulsory** |
| **Maximum Benefit** | $1,000,000 | $500,000 | $1,000,000 |
| **Benefit Coverage Period** | 3 Years | 2 Years | 3 Years |
| Motor Vehicle Accidents | Usual & Customary | $10,000 | |
| **Hospital Benefits** | | | |
| Hospital Room & Board Expense | Usual & Customary | $500/Day | |
| Hospital Intensive Care Unit Expense | Usual & Customary | $1,000/day, 5 day Maximum | |
| Miscellaneous Hospital Expense | Usual & Customary | $500 | |
| **Surgical Benefits** | | | |
| Surgical Expense | Usual & Customary | Usual & Customary | |
| Assistant Surgeon Expense | Usual & Customary | 25% of Surgical Expense | |
| Anesthetist or Anesthesiologist Expense | Usual & Customary | 25% of Surgical Expense | |
| Day Surgery Miscellaneous Expense | Usual & Customary | $500 | |
| **Medical Benefits** | | | |
| Outpatient Physician Expense | Usual & Customary | Usual & Customary | |
| Outpatient Consultant or Specialist Expense | Usual & Customary | Usual & Customary | |
| Outpatient Physical Therapy Expense | Usual & Customary to $10,000 Maximum | Usual & Customary to $2,000 Maximum | |
| Ambulance Expense | Usual & Customary | Usual & Customary | |
| Outpatient X-ray Expense | Usual & Customary | Usual & Customary | |
| Outpatient Laboratory Expense | Usual & Customary | Usual & Customary | |
| Outpatient MRI or CAT Scan Expense | Usual & Customary | $500 | |
| Outpatient Emergency Room Expense | Usual & Customary | $500 | |
| Outpatient Prescribed Medicine Expense | Usual & Customary | Usual & Customary | |
| Licensed Nurse Expense | Usual & Customary | Usual & Customary | |
| Outpatient Durable Medical Equipment and Supplies Expense | $5,000 | $2,000 | |
| Outpatient Dental Accident Expense | $50,000 | $500/Tooth | |
| Deferred Dental Treatment | When a dentist certifies that treatment will continue beyond the benefit period, an ADDITIONAL benefit of up to $1,000 will be paid. | | |
| Replacement of Eyeglasses, Hearing Aids, or Contact Lenses, if medical treatment is also received for the covered injury | $500 | $500 | |

# Accident Insurance Protection for Students

**Parents and Guardians: Do you have adequate insurance coverage for your child in the event of an unforeseen accident?**

**Bob McCloskey Insurance has got you covered!**

Depending on which program your child's school offers, you may be able to purchase one or more of the following insurance products on a voluntary basis...

- ✓ $500,000 At School Student Accident Coverage
- ✓ $500,000 Around the Clock - 24 Hour Accident Coverage
- ✓ $50,000 Student Accident Dental Coverage

...with relative ease from any computer or iPad via the following online address:

**www.bobmccloskey.com**

Just follow the instructions and you can accomplish the process in minutes. And, should you have any questions, you can call

**1-800-445-3126**

and a representative will be happy to assist you with the process or any questions.

**Bob McCloskey Insurance**
**P.O. Box 511 Matawan, NJ 07747**
**www.bobmccloskey.com**

Got You Covered