

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			
Parish Name	Policy#	KHH000200	
Parish Mailing Address		City, State, Zip	
Injured Person's Name	Birth date	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Date of Injury	Time	Type of Injury	Part of body injured
How did Injury occur?			
Volunteers General Duties:			
At the time of the injury, was the injured involved in an activity sponsored and supervised by the policy holder?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Name of Supervisor	Was he/she a witness to the accident?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/> If yes, please fill out Section A below.	
Is the injured Person Married? YES <input type="checkbox"/> NO <input type="checkbox"/>	Spouse's Name
Is the Spouse Employed? YES <input type="checkbox"/> NO <input type="checkbox"/> 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 <input type="checkbox"/> NO <input type="checkbox"/>	
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 <input type="checkbox"/> NO <input type="checkbox"/>	Is the Mother Employed? YES <input type="checkbox"/> NO <input type="checkbox"/>

SECTION A (INSURED)		SECTION B (SPOUSE)	
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.

Claimant Signature	Date
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## **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.