Statement of No Other Insurance

I , ______________________, declare that I was not covered
(Insured's Name)
by any other insurance policy, through myself or my parents for the accident dated ______________.
Should any insurance become effective during my treatment I will notify BMI Benefits and forward all eligible bills to the new carrier. I understand BMI Benefits coverage is excess to all other insurance and will pay after all collectible insurance.

I understand that if any of these statements are false it could deem my claim ineligible.

____ ____________

(Insured or Parent signature if insured is a minor) **(Date)**

FRAUD WARNING:
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.