TO: Summer Camp Administrators

FROM: Cheryl Harpe

DATE: June 11, 2020

RE: 2020 Summer Camp Insurance Coverage and Registration Information
   Policy # MCB5466773
   Coverage Term: 5/1/2020-6/1/2021

The 2020 Summer Camp Coverage for Archdiocesan Summer Camps has been renewed with
Bollinger Insurance Solutions through Zurich Insurance Company for all non-sports summer
camp participants for all activities and recreational sports excluding tackle football. Anyone
with tackle football camps will need to contact us for additional coverage. Summer Football
practice for high school teams is included in your regular Student Accident coverage. Coverage
for the Summer Camps outlined below.

PRIMARY EXCESS OVER $100
Benefits are payable for the first $100 of covered expenses, without regard to other insurance.
Thereafter, benefits are payable for covered expenses above $100 that are not recoverable from
another Plan Providing Medical Expense Benefits to the applicable maximum. The benefit
period is for (5) five years. If the insured is not covered by another Plan Providing Medical
Expense Benefits, the excess provision shall not apply and benefits are payable at first dollar.

Coverage limits are as follows:

$1,000,000 Maximum Medical Expense for Each Injury
$ 20,000 Loss of Both Hands, Both Feet or Sight of Both Eyes
$ 10,000 Loss of One Hand, One Foot or Sight of One Eye
$ 5,000 Loss of Life

Please complete the attached registration form once you know your enrollment numbers, make
your check payable to the Archdiocese of New Orleans and mail to Catholic Mutual Group,
1000 Howard Avenue, Suite 1202, New Orleans, LA 70113. If you have any questions on the
Summer Camp Coverage, please contact Jesenia Hamilton at 504-527-5769. All forms must be
turned in by August 30, 2020.
IN THE EVENT OF INJURY
*School/Parish complete numbers 1-17 on claim form. Keep a copy for your records. Give claim form to child’s legal guardian.

* Advise them the form must be submitted with (90) days.

*Claim Forms are attached for your use in case there are injuries. Please feel free to make copies.

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Attachments
LOCATION: 

ADDRESS:

This form will serve as your registration form. Fill in the number of participants and number of weeks, (whole weeks only) per category, compute the amount due and send your check, PAYABLE TO THE ARCHDIOCESE OF NEW ORLEANS, with this form by 8/1/2019. CATHOLIC MUTUAL GROUP, 1000 Howard Avenue, Suite 1202, New Orleans, LA 70113.

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<tr>
<th>PROGRAM</th>
<th>NUMBER OF PARTICIPANTS</th>
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GRAND TOTAL
1. School District or Diocese: ANO-Summer Camp  
2. School Within District or Parish Child Attends:  
3. Master Policy No.: MCB 5466773
4. Claimant's Last Name: First Name:  
5. Date of Birth:  
6. Male/ Female  
7. Telephone:  
8. Home Address:  
9. City/State/Zip Code:  
10. E-mail address of Parent of Guardian: 

11. Check activity in which student was involved when injured:  
   A. □ Interscholastic Sports  
   B. □ Cheerleading □ Twirling or Flagwaving □ Band Member
   OR:  
   01 □ Physical Ed. Class 04 □ To and From School 07 □ Extra Curr. Activity ON Premises  
   02 □ Classroom or Hallway 05 □ Group Travel 08 □ Extra Curr. Activity OFF Premises  
   03 □ Playground (NOT Phys. Ed.) 06 □ Non-School Activity (24 Hr. Plan) 09 □ Spectator

   Was School in Session? YES □ NO □  
   Starting Time ___________________________ Dismissal Time ___________________________

12. Date of Accident:  
13. Time: □ A.M. □ P.M.  
14. How Did Accident Occur?  
15. Where Did Accident Occur?  
16. Part of Body Injured: 

17. I certify that the activity checked above is school sponsored and supervised and is covered under a policy applied for and purchased by the policyholder.

Signature of School Official ___________________________ Title ___________________________ Date ___________________________

**AUTHORIZATIONS AND STATEMENT OF OTHER INSURANCE MUST BE COMPLETED BY PARENT OR GUARDIAN**

MEDICAL AUTHORIZATION: I authorize the release of any medical or other information necessary to process this claim, including all data covering this and/or previous confinements and/or disabilities.

SIGNED __________ DATE __________

PAYMENT AUTHORIZATION: I authorize payment of medical benefits directly to the providers rendering services.

SIGNED __________ DATE __________

1. Father's Name:  
2. Name and Address of His Employer:  
3. Mother's Name:  
4. Name and Address of Her Employer:  
5. □ No, we do not have any personal or group medical insurance. I have enclosed a letter from my employer verifying this.
6. □ Yes, we do have other insurance. (Please complete #7).
7. **Names of other Insurance Companies**
   Address
   
   
   
   
7. □ We have no other insurance. We are (please check one): □ Self-employed □ Unemployed □ Disabled
8. □ We have a government funded plan (Medicaid, TriCare, etc)

I hereby certify, swear and affirm that the information given above is true and accurate. I fully understand that any willful misrepresentation made by me in an attempt to collect benefits under this policy constitutes fraud and is punishable by law.

Parent or Guardian's Signature: ___________________________ Date __________

CLF-PRX-16-100
PARENTS' INSTRUCTION FOR FILING A CLAIM:

The Accident Insurance coverage purchased by the Board of Education/School provides coverage on a PRIMARY EXCESS BASIS. This means that for those claims where the total of all medical expenses incurred exceeds $100 that those expenses which are NOT covered by your own personal or group insurance are eligible for coverage, up to the limits of the policy.

MAIL THIS CLAIM FORM TO BOLLINGER WITHIN 90 DAYS OF THE DATE OF THE ACCIDENT

Please follow these instructions when filing a claim:

I. FOR CLAIMS TOTALING LESS THAN $100
   1. IMMEDIATELY submit Itemized Bills for all medical expenses to Bollinger, Inc.
      We cannot accept balance due bills.
   2. Please write claimant’s name, policy number and date of accident on all bills.

II. FOR CLAIMS TOTALING $100 or MORE:
   1. The statement of other insurance section on the other side of this form must be fully completed. If either (or both) parent(s) is employed but have no insurance, please complete a statement of verification from the employer(s) on their letterhead.
   2. After your primary insurance has paid the medical expenses up to the policy limits, submit Itemized Bills (CMS-1500 from physicians, UB-04 from hospitals, and ADA Dental claim form J430 or its equivalent for dental injuries) AND copies of the Explanation of Benefits from your primary insurance company as you receive them and mail to the address shown below. We cannot accept balance due bills.
   3. Please write the claimant's name, policy number, and date of accident on all Bills and Explanation of Benefits. A new claim form is not necessary.
   4. Please keep a copy of this claim form, all bills and primary insurance Explanation of Benefits for your own records.
   5. If you need further information call 866-267-0092 or contact us on our website at: www.BollingerSchools.com. DO NOT CALL THE SCHOOL.

MAIL THIS CLAIM FORM TO BOLLINGER WITHIN 90 DAYS OF THE DATE OF THE ACCIDENT.

Thank you for your cooperation.

Please keep a copy of this Claim Form, all bills and primary insurance Explanations of Benefits for your records.

Network Provider:

www.multiplan.com

PLAN ADMINISTRATION AND CLAIM SERVICE BY:

Bollinger Specialty Group

BOLLINGER, INC., A SUBSIDIARY OF
ARTHUR J. GALLAGHER & CO.

P.O. BOX 1346, MORRISTOWN, N.J. 07962 • TELEPHONE 866-267-0092

www.BollingerSchools.com