



**SPECIALTY INSURANCE**

## K-12 STUDENT

### ACCIDENT CLAIM FORM

Please complete and submit to A-G Specialty Insurance with itemized medical bills **AND primary insurance explanation of benefits**

Send all claim forms and documents using our secure upload portal: [upload.agadministrators.com](https://upload.agadministrators.com)  
Alternatively, submit documents to [claims@agadm.com](mailto:claims@agadm.com).

For **questions**, however, please contact  
A-G Specialty Insurance: [customerservice@agadm.com](mailto:customerservice@agadm.com).

#### YOUR INFORMATION (School Official)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Title: \_\_\_\_\_ School/Organization Name: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

#### POLICYHOLDER INFORMATION

Policyholder (School): Diocese of Metuchen - Policy # MCB-0553602-04

School Address: 146 Metlars Ln. Piscataway NJ, 08854  
STREET CITY STATE, ZIP

#### PARTICIPANT INFORMATION

Participant's Name: \_\_\_\_\_  
FIRST NAME MIDDLE INITIAL LAST NAME

Date of Birth: \_\_\_\_\_ Sex: ☐ M ☐ F Social Security #: \_\_\_\_\_

Participant's Phone Number (or Parent's if minor): \_\_\_\_\_

Participant's EMAIL (or Parent's if minor): \_\_\_\_\_

Participant's Home Address: \_\_\_\_\_  
STREET CITY STATE, ZIP

#### ACCIDENT INFORMATION

Circumstance: ☐ Game ☐ Practice ☐ Conditioning ☐ Other (Please explain in Nature of Injury section.)

Activity/Sport (if athletic related): \_\_\_\_\_ Accident Date: \_\_\_\_\_

Body Part Injured: \_\_\_\_\_ Place of Accident: \_\_\_\_\_

Nature of Injury (Details of what happened.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### INSURANCE INFORMATION

Does the claimant have Other insurance? ☐ Yes ☐ No (Attach separate documents if necessary.)

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_  
STREET CITY STATE, ZIP

Policy Number: \_\_\_\_\_ ID#: \_\_\_\_\_

Is the participant eligible for Medicaid or TriCare Benefits? ☐ YES ☐ NO

If yes, please file for benefits under the Participant Accident Plan before submitting expenses to Medicaid or TriCare.



**A-G SPECIALTY INSURANCE, LLC**

PO Box 21013, Eagan, MN 55121

Ph: (610) 933-0800 Fx: (610) 933-4122 Email: [claims@agadm.com](mailto:claims@agadm.com)

## AUTHORIZATION

**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 A-G Specialty Insurance to the extent for which A-G Specialty Insurance would not have been liable.

**AUTHORIZATION TO RELEASE INFORMATION:** I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to A-G Specialty Insurance and its designees.

**PAYMENT AUTHORIZATION:** I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

**WARNING:** New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

**PARTICIPANT SIGNATURE** *(Parent or guardian, if participant is a minor)*

**DATE**

**ORGANIZATION/POLICYHOLDER SIGNATURE**

**TITLE**

**DATE**

**FRAUD WARNING:** Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**Alaska:** Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**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

**Arkansas and Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, 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.

**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 for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Delaware:** Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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

**Idaho and Indiana:** Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony. Idaho and Indiana: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

**Kentucky:** 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.

**Louisiana and West Virginia:** 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.

**Maine, Tennessee, Virginia and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any 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.

**New Mexico:** 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 CIVIL FINES AND CRIMINAL PENALTIES.

**Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma:** WARNING: Any person, who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto, may be subject to prosecution for insurance fraud.

**Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 subjects such person to criminal and civil penalties.

**Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (\$5,000) dollars and not more than ten thousand (\$10,000) dollars and not more than ten thousand (\$10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**Texas:** 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



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P.O. Box 21013, Eagan, MN 55121

Ph: (610) 933-0800 Email: [claims@agadm.com](mailto:claims@agadm.com)



**Bollinger Specialty Group**  
A Gallagher Company

## 2024-2025 Student Accident Insurance

### Claims Filing Instructions

#### Cut out or Show Your Medical Provider

**Bollinger Specialty Group**

A Gallagher Company

**Student Accident  
(Secondary/Excess Insurance)**

Providers & Hospitals, please bill A-G Specialty Insurance directly including the name of Patient, Name of District, Diocese or Independent School and Diagnosis on all bills.  
*This is not a contract of insurance. The terms and conditions of coverage are set forth in the Policy issued to the school / Policyholder. The Policy is subject to the laws of the state in which it was issued.*

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**SEND ALL FORMS TO  
CLAIMS ADMINISTRATOR:**

**A-G Specialty Insurance  
PO Box 21013  
Eagan, MN 55121  
or email to:**

**[claims@agadm.com](mailto:claims@agadm.com)**

**Questions: Please contact our Customer  
Service Department @  
1-866-267-0092**

### FREQUENTLY ASKED QUESTIONS

**Q. What is the purpose of Secondary/Excess Accident Insurance?**

A. The coverage is intended to help cover medical expenses related to a covered injury that results from your participation in school's activities. The policy pays **after** any other valid/collectible insurance that the student carries. It is designed to cover expenses left to the patient's responsibility on their primary insurance Explanation of Benefits (EOB), such as co-pays, deductibles, and coinsurance for eligible medical treatment, subject to policy limitations and exclusions.

**Q. In addition to the Claim Form, what documents are needed in order for the Student Accident Insurance to process a claim?**

A. The provider must submit the following documents to the Claims Administrator, A-G Specialty Insurance:

- 1) Itemized Medical Bill – The provider will either bill the claims administrator with a CMS 1500 or UB04, and it will contain the following information:
  - Provider's Name and address
  - Tax ID Number
  - Date(s) of Service
  - Diagnostic Code(s) and Procedure Code(s)
  - The Fee for Each Procedure
- 2) Primary Explanation of Benefits (EOB) – This is a statement from your primary insurance company that outlines what charges will be covered or denied, and what will be left as patient responsibility (co-pay, coinsurance, deductible, etc.).

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