Carrier and Claims Company Information

Carrier Name	QBE Specialty Insurance
City, State	New York, NY
A.M. Best Rating	A (Excellent)
S&P Rating	A+
Moody's Rating	A3
Fitch Rating (if applicable)	A+
Carrier Description	QBE Specialty Insurance is part of QBE Insurance Group Limited, one of the top 25 insurers and reinsurers worldwide. Headquartered in Sydney, Australia, QBE operates in 45 countries around the globe, with a presence in every key insurance market. The Americas Division, headquartered in New York, conducts business through various property and casualty insurance subsidiaries in eight countries. QBE's Americas Division produced more than $3.7 billion in gross written premium in 2008, and has a policyholder's surplus of more than $1.7 billion. QBE Insurance companies are rated "A" (Excellent) by AM Best and "A+" by Standard and Poor's. For more information visit qbe.com.
Claims Company Name	**Bob McCloskey Insurance / BMI Benefits, LLC.**
City, State	Matawan, New Jersey
Years of serving student insurance industry	35+
Claims Submission Information	
Nationwide Toll-Free Number	800-445-3126
Claim Form Required? Yes/No	Yes
Claim lookup online? Yes/No	Yes
Claim Submission Deadline	90 days or as soon as possible, or within 90 days of date of injury or first treatment for the injury. Medical bill, HCFA 1500 or UB92 should be used to submit expenses
Mailing address for claim submission	PO Box 511 76 Main Street, Matawan, NJ 07747
E-mail address for claim submission	Clerk@bobmccloskey.com
Website	bobmccloskey.com
Customer Service Hours (EST)	9:00a.m. - 5:00p.m.
Assigned Specific Claims Examiner? Yes/No	Yes
Claims Processing Time for a complete claim while maintaining a 98.9% financial accuracy (# of days/range)	30 business days
HIPAA Compliance with federal privacy and confidentiality requirements Yes/No	Yes

HOW TO FILE A 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 800-445-3126 (P) 732-583-9610 (F)

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.

Got You Covered

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

PART 1A: POLICYHOLDER

School/Organization | Policy#

School Mailing Address | City, State, Zip

Injured Person's Name | Birth date | Male □ Female □

Date of Injury | Time | Type of Sport | Part of body injured

How did Injury occur?

Sport Designation: Intercollegiate ◯ Intramurals ◯ Practice ◯ Game ◯ Other ◯

At the time of the injury, was the injured involved in an activity sponsored and supervised by the policy holder? YES ◯ NO ◯

Name of Supervisor | Was he/she a witness to the accident? YES ◯ NO ◯

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 ◯ NO ◯ If yes, please fill out Section A below.

Is the injured Person Married? YES ◯ NO ◯ Spouse's Name

Is the Spouse Employed? YES ◯ NO ◯ 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 ◯ NO ◯

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 ◯ NO ◯	Is the Mother Employed? YES □ NO □

SECTION A (INSURED/FATHER)	SECTION B (SPOUSE/MOTHER)
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, 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