CATHOLIC MUTUAL GROUP®

serving the temporal needs of the church since 1889

***NO NEED TO RESPOND IF YOU DO NOT HAVE A CAMP**

TO: Summer Camp Administrators

FROM: Cheryl Harper

DATE: May 28, 2019

RE: 2019 Summer Camp Insurance Coverage and Registration Information
Policy # MCB5466773
Coverage Term: 6/1/2019-6/1/2020

The 2019 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, 2019.

1000 Howard Avenue, Suite 1202
New Orleans, LA 70113-1941
(504) 527-5760
(877) 527-5760
Facsimile (504) 527-5799

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

Archdiocese of New Orleans-Insurance Office
1000 Howard Ave., Ste. 1202, New Orleans, LA 70113
2019 SUMMER CAMP BILLING

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.

PROGRAM	NUMBER OF PARTICIPANTS	NUMBER OF WEEKS	COST PER PERSON PER WEEK	TOTAL COST
Regular Day Camp			$2.25	
Over Night Camps			$3.50	
Wrestling Camps			$4.50	
• Age 12 & Under				
• Age 13 to 18			$6.00	
Tumbling Camps			$4.50	
• Age 12 & Under				
• Age 13 to 18			$7.00	
			$9.50	
Non-Contact-Flag Football			$4.50	
• Age 12 & Under				
• Age 13 to 18			$7.00	
Baseball			$3.25	
• Age 12 & Under				
• Age 13 to 15			$4.50	
• Age 16 to 18			$6.00	
Basketball			$3.00	
• Age 12 & Under				
• Age 13 to 15			$4.25	
• Age 16 to 18			$5.75	
Cabbage Ball			$2.50	
• Age 12 & Under				
• Age 13 to 15			$3.00	
• Age 16 to 18			$3.25	
Cheerleading			$2.75	
• Age 12 & Under				
• Age 13 to 18			$3.50	
Dance			$2.75	
• Age 12 & Under				
• Age 13 to 18			$3.50	
Soccer			$3.25	
• Age 12 & Under				
• Age 13 to 15			$4.50	
• Age 16 to 18			$5.75	
Tennis			$2.50	
• Age 12 & Under				
• Age 13 to 18			$5.75	
Volleyball			$2.50	
• Age 18 & Under				
Weightlifting			$4.50	
• Age 13 to 16				
• Age 16 to 18			$6.00	

GRAND TOTAL

-PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING-

SEND ALL FORMS TO CLAIMS ADMINISTRATOR:
BOLLINGER INC.
P.O. Box 1346
Morristown, NJ 07962

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_____ (Name of Sport)

B. ☐ Cheerleading ☐ Twirling or Flagwaving ☐ Band Member

OR:

01 ☐ Physical Ed. Class
02 ☐ Classroom or Hallway
03 ☐ Playground (NOT Phys. Ed.)
04 ☐ To and From School
05 ☐ Group Travel
06 ☐ Non-School Activity (24 Hr. Plan)
07 ☐ Extra Curr. Activity ON Premises
08 ☐ Extra Curr. Activity OFF Premises
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**

8. ☐ We have no other insurance. We are (please check one): ☐ Self-employed ☐ Unemployed ☐ Disabled

9 ☐ **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 can-not 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