

**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.**