

# CHUBB®

## ACE American Insurance Company

**MAIL TO:**  
**Administrative Concepts, Inc.**  
PO Box 4000  
Collegeville, PA 19426  
[www.visit-aci.com](http://www.visit-aci.com)

**BOTH SIDES OF CLAIM FORM  
MUST BE COMPLETED AND  
RETURNED WITH ITEMIZED  
BILLS WITHIN 30 DAYS.**

**EDI PAYOR ID# 22384**

Any person who knowingly presents a false or fraudulent claim for payment of 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.

**-PLEASE PRINT ALL INFORMATION-**

**PARTS I & II MUST BE COMPLETED AND SIGNED BY STUDENT**

|                               |  |               |                |
|-------------------------------|--|---------------|----------------|
| Name of Group, City and State | Graduate <input type="checkbox"/> Domestic <input type="checkbox"/><br>Undergraduate <input type="checkbox"/> International <input type="checkbox"/> | Policy Number | Birth Date     |
| Insured Member's Name         | LAST NAME  | FIRST NAME    | MIDDLE INITIAL |
| Present Address               | NO. AND STREET   | CITY OR TOWN  | STATE          |
| Home Address                  | NO. AND STREET   | CITY OR TOWN  | STATE          |

If claim for dependent, give dependent's name \_\_\_\_\_ relationship to Insured \_\_\_\_\_ Age \_\_\_\_\_

| COMPLETE THIS SECTION FOR ACCIDENT CLAIM  | COMPLETE THIS SECTION FOR SICKNESS CLAIM   |
|---|--|
| Nature of Injury (Describe fully, including which part of body was injured.) _____  | Date of Sickness _____   |
| Describe How, When and Where Accident Occurred (Include Date and Time) _____  | Date symptoms first noticed _____  |
| Was the injury due to practice or play of a sport? <input type="checkbox"/> Yes <input type="checkbox"/> No   | What is the exact nature of the sickness _____   |
| Which Sport?<br><input type="checkbox"/> Intercollegiate <input type="checkbox"/> Intramural <input type="checkbox"/> Club <input type="checkbox"/> Other | If pregnancy, date of last menstrual period _____  |
| Is condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No   | Have you ever had the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No                                |
| Is condition due to auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No   | If yes, date of first treatment _____  |
| If yes, please attach detailed policy information on all motor vehicles involved in accident.   | Date of last treatment _____   |
| Were you treated in the Health Service for this condition?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                    | Were you treated in the Health Service for this condition?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                   |
| Seen by: _____ Date: _____  | Seen by: _____ Date: _____   |
| If your claim is for services outside of the Health Service, were you referred? <input type="checkbox"/> Yes <input type="checkbox"/> No                  | If your claim is for services outside of the Health Service, were you referred? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If not, why? Away from school<br>For what reason: _____   | If not, why? Away from school<br>For what reason: _____  |

**Administrative Concepts, Inc. does not share private health information except as required or permitted by law. We are committed to guarding the private information entrusted to us.**

**PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE, UNLESS A PAID RECEIPT IS ATTACHED AT THE TIME OF SUBMISSION.**

To any medical care provider, medical care facility, Insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Administrative Concepts, Inc. or the underwriting company. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The Company will use this information to determine if my claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigative or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization. I certify that the information given by me in support of my claim is true and correct.

**Patient's or Authorized Representative's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**If Authorized Representative, Relationship to Patient** \_\_\_\_\_

**or Legal Designation** \_\_\_\_\_

STREET

CITY

STATE

ZIP CODE + 4

**PART II**

*Please Print All Information*

Have you been covered (as an insured or dependent) by any other hospital and/or medical plan for the past 12 months?  Yes  No

If yes, indicate the name and address of the company \_\_\_\_\_

Effective date of coverage: \_\_\_\_\_ Expiration date: \_\_\_\_\_ Policy No. \_\_\_\_\_

Have you filed a claim with any other insurance company?  Yes  No

I hereby certify that the above information given by me in support of this claim is true and correct.

Patient's or Authorized Representative's Signature \_\_\_\_\_ Date \_\_\_\_\_

If Authorized Representative, Relationship to Patient \_\_\_\_\_

or Legal Designation \_\_\_\_\_

**The following section is applicable if you are covered under any other medical insurance plan.**

Mother's Name \_\_\_\_\_ Employer's Telephone # \_\_\_\_\_ Policy No. \_\_\_\_\_

Employer's Name and Address \_\_\_\_\_

Name and Address of Insurance Co. \_\_\_\_\_

Father's Name \_\_\_\_\_ Employer's Telephone # \_\_\_\_\_ Policy No. \_\_\_\_\_

Employer's Name and Address \_\_\_\_\_

Name and Address of Insurance Co. \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Employer's Telephone # \_\_\_\_\_ Policy No. \_\_\_\_\_

Employer's Name and Address \_\_\_\_\_

Name and Address of Insurance Co. \_\_\_\_\_

## IMPORTANT NOTICE

**Notice to Alaska Claimants:** A 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.

**Notice to Arizona Claimants:** 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.

**Notice to Arkansas Claimants:** 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.

**Notice to California Claimants:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents 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.

**Notice to Colorado Claimants:** 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 from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

**Notice to District of Columbia Claimants: 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.

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

**Notice to Idaho Claimants:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information, is guilty of a felony.

**Notice to Indiana Claimants:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Notice to Kentucky Claimants:** 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.

**Notice to Maine Claimants:** 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.

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

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

**Notice to New Hampshire Claimants:** 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.

**Notice to New Jersey Claimants:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Notice to New Mexico Claimants:** 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.

**Notice to New York Claimants Fraud Warning:** 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 material 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.

**Notice to Ohio Claimants:** Any person who, with the 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.

**Notice to Oklahoma Claimants: 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.

**Notice to Oregon Claimants WARNING:** Any person who, knowingly and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud.

**Notice to Pennsylvania Claimants Fraud Warning:** 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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Notice to Rhode Island Claimants WARNING:** 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.

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

**Notice to Claimants in all other states:** Any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.