CHUBB

ACE American Insurance Company

MAIL TO:
Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426-9000
www.acitpa.com

CLAIM FORM MUST BE COMPLETED AND RETURNED 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-
MUST BE COMPLETED AND SIGNED BY STUDENT

Name of Group, City and State		Policy Number	Birth Date
ISM INTERNATIONAL PLAN	Domestic ☐ International ☐	**GLMN00174646**	

Insured Member's Name _____
LAST NAME | FIRST NAME | MIDDLE INITIAL | MEMBER ID# | PHONE #

Present Address _____
NO. AND STREET | CITY OR TOWN | STATE | ZIP CODE +4

Home Address _____
NO AND STREET | CITY OR TOWN | STATE | ZIP CODE +4

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

COMPLETE THIS SECTION FOR ACCIDENT CLAIM

Nature of Injury (Describe fully, including which part of body was injured.) _____

Describe How, When and Where Accident Occurred

Include Date and Time: _____

Was the Injury due to practice or play of a sport? ☐ Yes ☐ No

Which Sport?
Intercollegiate ☐ Intramural ☐ Interscholastic ☐
Club ☐ Other ☐

Is condition work related? ☐ Yes ☐ No

Is condition due to an auto accident? ☐ Yes ☐ No

If yes, please attach detailed policy information on all major vehicles involved in accident.

Were you treated in the Health Service for this condition?
☐ Yes ☐ No

Seen by: _____ Date: _____

If your claim is for services outside of the Health Service, were you referred? ☐ Yes ☐ No
If not, why? Away from school
For what reason: _____

COMPLETE THIS SECTION FOR SICKNESS CLAIM

Date of Sickness _____

Date symptoms first noticed _____

If pregnancy, date of last menstrual period _____

What is the exact nature of the sickness? _____

Have you ever had the same or similar condition? ☐ Yes ☐ No

If yes, date of first treatment _____

Date of last treatment _____

Were you treated in the Health Service for this condition?
☐ Yes ☐ No

Seen by: _____ Date: _____

If your claim is for services outside the Health Service, were you referred? ☐ Yes ☐ No

If not, why? Away from school
For what reason: _____

PLEASE PRINT, SIGN AND MAIL THIS FORM TO ADMINISTRATIVE CONCEPTS, INC.

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 authoriza tion. 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. _____

IMPORTANTNOTICE

Notice of Alabama Claimants: 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.
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 information to obtain or amend insurance coverage or to make a 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 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 Delaware Claimants: 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.
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 of claim containing any false, incomplete, or misleading information, is guilty of a felony. The lack of such a statement shall not constitute a defense against prosecution under this section.
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 of Louisiana 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 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 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.
Notice to Minnesota Claimants: A person who 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 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 persons 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 of Tennessee 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 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 of Washington 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 of West Virginia 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 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.

It is important to note that CHUBB North American Claims and the Accident & Health Division reserves its right to make changes to this language and may require additional fraud warnings incorporated onto the claim forms in the future.

Procedures for Submitting a Claim Form for ACE American Insurance Company's International Student Accident & Sickness Insurance (ISAS)

Should an accident or illness occur requiring that a claim be submitted, please follow these instructions to ensure speedy and accurate payment.

- This coverage is underwritten by ACE American Insurance Company. Policies are issued and claims are paid by Administrative Concepts, Inc (ACI). Refer to your ID Card for information on your policy. You can reprint a copy of your ID Card from ACI's website (www.acitpa.com). In order to utilize ACI's website, you must be registered.

- *Claim Forms:* You can obtain a Claim Form from your school's health office or online (https://secure.acitpa.com/enrollment/home/ism.htm). All claims must be submitted on the proper form. Complete in full, sign, and return the Claim Form, along with all itemized bills, to the below address within 30 days of the visit. **If the claim is for an accident, explain what happened and identify the injured area of the body. Please do not omit any information when filling out the Claim Form- failure to complete the form in its entirety may result in payment being delayed.**

Administrative Concepts, Inc. (ACI)
P.O. Box 4000
Collegeville, PA 19426-9000

Phone: 800-715-7261

- Contact all physicians, hospitals, and other healthcare providers who have treated you or will be treating you, and give them the information about your insurance. You can ask the providers to bill ACI directly at the above address. If the providers will not bill the insurance for you, request copies of all the bills; **include the name of the provider, date of service, the charges, the diagnosis codes, procedure codes, and the provider's Federal Income Tax ID Number. ACI cannot process claim payments from balance due statements or collection notices.**

- Be sure to attach a copy of any bills you may have to the Claim Form. Future bills can be submitted to ACI on their own. **Providers may submit bills electronically using Payor # 22384.** Please make sure your name and ID Number are clear on all paperwork.

- If you have paid any providers directly, be sure to attach a receipt of payment to the itemized bill. Please let ACI know whom to reimburse (to whom the check should be made payable, and where reimbursements should be sent).

- Make copies of all forms for your records.

- You will receive a response from ACI within 2 weeks.

- You can check the status of your claim on ACI's website- www.acitpa.com, or call ACI's claim department at 800-715-7261.

Contact Tascha Gourley at ISM
to request more claim forms.
Phone: 302-656-4944
E-mail: Tascha@isminc.com

ism® Insurance Inc.

Independent School Management
CREATIVE THINKING,
PROVEN RESULTS