BLANKET ACCIDENT & SICKNESS CLAIM FORM/CHILDREN'S CAMPS/SCHOOLS

CHUBB®

ACE American Insurance Company

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

INSTRUCTIONS:
1.) Please complete in full if initial submission. Complete first 2 lines, sign and date if subsequent submission.

2.) Please attach fully itemized bill(s) including: Patient's Name, Date of Service, Place of Service, Diagnosis, Procedure Code and Description of Services.

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.

Name of Camp/School (as appears on policy)		**Sponsoring Organization** (if any)	
Address of Camp/School (Including city & state)		**Camp's/School Policy Number**	**Camp's Certificate Number**
Claimant's Name	**Date of Birth**	**Member Identification #**	**Parent's Names(if claimant is minor)**
Claimant's Address		**City**	**State** / **ZIP**
Date Claimant Arrived		**Date Claimant Schedule to Leave**	**Phone Number**

IF AN ACCIDENT CLAIM, COMPLETE THIS SECTION

Date of Accident: _____ Hour: _____ ☐ AM ☐ PM

Type of Injury:
- ☐ Bruise/contusion/abrasion
- ☐ Burn
- ☐ Fracture
- ☐ Dislocation
- ☐ Laceration
- ☐ Sprain/Strain
- ☐ Other: _____

Part of Body Injured:
- ☐ Ankle
- ☐ Arm
- ☐ Elbow
- ☐ Face
- ☐ Foot (incl. toes)
- ☐ Hand (incl. fingers)
- ☐ Head
- ☐ Knee
- ☐ Leg
- ☐ Shoulder
- ☐ Tooth
- ☐ Wrist
- ☐ Other: _____

Activity at time of Injury
- ☐ Dining Hall Activity
- ☐ Horseback Related
- ☐ Playground Related
- ☐ Running
- ☐ Swimming
- ☐ Walking
- ☐ Other Non-Sports _____
- ☐ Sports-related:
  - ☐ Baseball
  - ☐ Basketball
  - ☐ Football
  - ☐ Field Hockey
  - ☐ Softball
  - ☐ Soccer
  - ☐ Tennis
  - ☐ Volleyball

Where did accident occur? _____ ☐ On premises ☐ Off premises ☐ Other Sports: _____

Was Claimant involved in a sponsored activity at the time of claim? ☐ YES ☐ NO

Was Claimant working at the time of claim? ☐ YES ☐ NO

IF A SICKNESS CLAIM, COMPLETE THIS SECTION

Date of Sickness: _____ Hour: _____ ☐ AM ☐ PM

Describe sickness or condition: _____

FOR ALL CLAIMS, COMPLETE THIS SECTION

Does the Claimant have other insurance? ☐ YES ☐ NO

If yes, name of company: _____ Subscriber's policy number: _____

Address: _____

Is this a pre-existing condition? ☐ YES ☐ NO

To whom should payment be made? ☐ CAMP ☐ SCHOOL ☐ CLAIMANT ☐ PARENT ☐ PROVIDER OF SERVICE

I hereby certify that the above is a covered individual under the policy and that the injury or sickness was sustained in accordance with the policy provisions.

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

Camp Official's Name (PRINT) Camp Official's Name (SIGNATURE) DATE