The CHUBB Underwriting Companies

Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426-9000
www.visit-aci.com

Group Name: ____________________

Policy Number: ____________________

FRAUD WARNING: 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.

Patient Information:

First Name: ____________________ MI: ________ Last Name: ____________________

Q.•˘¦^åqÁPæ{ ^ ____________________

DOB: ____________________ Member ID: ____________________

Address: ____________________ Apt #: ____________

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City: ____________________ State: ____________________ Zip: ____________

Phone: ____________________

Email: ____________________

Claim Information:

1) Exact Nature of Injury or Illness: ____________________

a. If Injury, Description of Accident: ____________________

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Date of Last Menstral Period: ____________________

Physicians Name: ____________________

Physicians Contact Information: ____________________

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2) Date of Occurrence: ____________________

3) Is condition work related? YES NO

4) Is condition due to an auto accident? YES NO

a. If yes Driver License #: ____________________ State: ____________________

b. What type of Vehicle: ____________________

5) Hospital Admission Date: ____________________ Discharge Date: ____________________

6) Was your stay in: Semi-Private: ICU: Observation:

# of Days: ________ # of Days: ________ # of Days: ________

7) Name of Hospital: ____________________

City: ____________________ State: ____________________

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.

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.

X____ ________________________________

Patient or Authorized Representatives Signature **Date**