MAIL TO:
Administrative Concepts, Inc.
P.O. Box l000
CollegevilleÊÚŒÆFJ426Ë9000
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www.acitpa.com

ACCIDENT CLAIM FORM

CHUBB®

ACE American Insurance Company

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.

PART A - This PART **MUST** be **completed, dated** and **signed** by an official of the Organization.

1. Name of Organization (Policyholder)	2. Policy No.	3. Name of the Organization or Team (if different from Policyholder)

4. Address of Organization (Street) (City) (State) (Zip)

5. Name of Injured Person (Insured) (First) (Middle) (Last)

6. Date of Accident/Injury Mo. Day Year / /	7. Injury Occurred: Practice ❑ Travel ❑ Game ❑ Other ____________	8. Type of Sport or Activity:

9. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report Form, attach a copy of the Report.

10. Describe the nature of the injury.

11. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes ❑ No ❑	12. Name of Supervisor of Activity	13. Was he/she a witness to the accident? Yes ❑ No ❑

14. Signature of Organization Official x______________________	15. Title of Official	16. Area Code/Telephone No.	17. Date Signed

PART B - This PART **MUST** be **completed, dated** and **signed** by the Injured Person - or if the Injured Person is under age 18 or otherwise dependent - by his/her Parent or Guardian.

PRINT HERE - NAME OF PERSON COMPLETING FORM: Check one: Injured Person ❑ Parent ❑ Guardian ❑

Give the following information about the Injured Person:

1. Date of Birth Mo. Day Year / /	2. Male ❑ Female ❑	3. Social Security No. / /	4. Area Code/Telephone No. ( )

5. Address (Street) (City) (State) (Zip)

6. Employer (Name) (Address (Street) (City) (State) (Zip)

Area Code / Employer Telephone No.

7. Is the Injured Person covered under any other health and/or accident insurance plans? Yes ❑ No ❑
If YES, Give the following information:

Name of other Insurance Company(s)	Address of other Insurance Company(s)	Policy Numbers(s)	Name of Policyholder(s)

8. If the Injured Person is under 18 or otherwise dependent, give the following information:

Name of Father or Male Guardian	Place of Employment	Area Code/Employer Phone No. ( )
Name of Mother or Female Guardian	**Place of Employment**	**Area Code/Employer Phone No. ( )**

9. If the Injured Person is married, give the following information:

Name of Spouse	Place of Employment	Area Code/Employer Phone No. ( )

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

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 ia eligible. Any information obtained will not be released by 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. I understand that the intentional furnishing of incorrect information via the US Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Administrative Concepts, Inc. to the extent for which Administrative Concepts, Inc. would not have been liable.

Patient's or Authorized Representative's Signature ______________________ Date ____________

If Authorized Representative, Relationship to Patient ______________________

or Legal Designation ______________________
STREET CITY STATE / ZIP

INSTRUCTIONS

1. PART A - must be completed by the school.
2. PART B - must be completed by Parent or Guardian.
3. Attach all itemized medical bills you have received to date. Later bills can be mailed to the insurance company separately. Please show name of school on all later bills.
4. Mail this report and bills within 30 days after the first treatment to:

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

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 in 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 in 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.

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.