CHUBB®

MAIL TO:
Administrative Concepts, Inc.
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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

Group Name: Policy Number Birth Date

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 ☐ Club ☐ Other

Is condition work related? ☐ Yes ☐ No

Is condition due to auto accident? ☐ Yes ☐ No

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

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

Seen by: _____ Date: _____

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

If not, why? _____

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. _____