CHUBB®

Insurance Claim Filing Instructions

PROOF OF LOSS CONSISTS OF THE FOLLOWING:

1. A completed and signed Claim form and Attending Physician's Statement.
2. **For Hospital/Intensive Care/Hospital Services Coverage -** All UB92 hospital bills, HCFA1500 physician's bills, physician's superbills (these are standard billing statements used by your provider of service).
3. FOR HMO or Medicare Insureds, please submit verification of confinement from the hospital if a UB92 hospital bill is not available.
4. **For Surgical, Anesthesia or Ambulance Coverage –** Send copy of the bills.
5. ALL BILLS MUST INCLUDE A DIAGNOSIS FROM YOUR PROVIDER OF SERVICE.
6. Evidence of change of name of Member, Dependent or Beneficiary. (if applicable)

Return Proofs of Loss (*listed above*) to:

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

Note: If you need additional space in order to complete the Claim Form, please attach a separate sheet of paper with your responses.

When the loss was due to…

Cancer, a pathology report verifying a malignancy MUST BE PROVIDED for all initial claim submissions.

This claim form has been sent to you as requested in anticipation of a claim being filed. Administrative Concepts, Inc is unable to begin processing your claim until all completed forms and documents are received by Administrative Concepts, Inc. If we do not receive the completed claim form within 30 days of your receipt of the claim form, we will assume you no longer wish to file a claim. If you need assistance please contact us at the toll free number as noted below.

If you have any questions, please call us toll free at:

888-293-9229

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CANCER INSURANCE

MEMBER INFORMATION				
Name (Last, First, Middle)		Please also list all other names by which the Member is known:		
Address: Is this a new address: _____	City	State	Zip	Phone: (_____)_____
Date of Birth:	Social Security Number (required):	Sex: _____Male ____Female		Marital Status:
Your Citizenship: (_____) U.S. (_____) Other (please indicate) _____				
Policy Number:	Certificate Number:	How are premiums paid?		Name of Association:

DEPENDENT INFORMATION (ONLY COMPLETE IF CLAIM IS FOR DEPENDENT)				
Name (Last, First, Middle)		Please also list all other names by which the Dependent is known:		
Address: Is this a new address: _____	City	State	Zip	Phone
Date of Birth:	Social Security Number (required):	Sex: _____Male ____Female		Marital Status:
Relationship to Member: Spouse ____ Child _____ Other _____				

CLAIM DETAILS		
Date of Loss: _____	Have you claimed benefits for this condition previously? _____	Are you claiming Wellness Benefits: _____ Yes _____ No If Yes, please attach bills

Have you used ambulance due to this condition to or from the hopsital or Skilled Nursing Facility? _____ Yes _____ No
If yes, please provide copies of bills.

Have you had chemotherapy or radiation treatment? _____ Yes _____ No

If Hospital Confined: Admission Date: _____ Discharge Date: _____

Hospital Name:_____ Hospital Phone:_____)_____

Address: _____ Physician Name:_____

City _____ State_____ Zip code: _____ Phone:(_____)_____

I am filing this claim as the ☐ Member ☐ Executor ☐ Administrator ☐ Guardian ☐ Power of Attorney
If you are claiming as other than Member, please provide proof of your authority to represent the Member.

I certify that the foregoing statements and answers on this form are complete and true to the best of my knowledge.

Signature: _____ **Date**: _____

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ATTENDING PHYSICIAN'S STATEMENT FORM

PATIENT INFORMATION

Name (Last, First, Middle)		Please also list all other names by which the Patient is known:
Date of Birth:	Social Security Number:	Address:

THIS SECTION IS TO BE COMPLETED BY YOUR PHYSICIAN

1. Date of First Symptoms: _____/_____/_____	2. Date First Consulted for this Condition: _____/_____/_____	3. Date Condition First Diagnosed: _____/_____/_____

4. Has Patient ever been previously treated for this condition or related condition? _____ If yes, give date and diagnosis or prior advice and treatment:

5. Name and Address of Physician who referred this Patient:

6. Name and Address of Hospital where services were rendered:

7. Name and Address of Skilled Nursing Facility where services were rendered:

8. For Services Performed in Hospital:	9. For Services Performed in Skilled Nursing Facility:
Admission date: ____/____/____ Discharge date: ____/____/_____	Admission date: ____/____/___ Discharge date: ____/____/___

Inclusive Dates Patient was confined in Hospice: From: ____/____/____ to: ____/____/_____

Please provide names and Addresses of other Physicians currently treating Patient:

Diagnosis of illness or injury requiring services (Relate Diagnosis to procedure by reference to numbers 1, 2, 3, etc in column D)

1.

2.

3.

13. A	B	C		D	E
Date of each Service	Place of Service: * See code Below	Describe surgical or Medical procedures and other Services furnished for each date given		DX. No.	CHARGES
		Procedure Code	(Explain unusual circumstances)		

* Place of Service Codes			
1-(IH) Inpatient Hospital 2-(OH) Outpatient Hospital 3-(O) Doctors Office	4-(H) Patient's home 5-Psychiatric Day Care Facility 6-Psychiatric Night Care facility	7-(NH) Nursing Home 8-(SNF) Skilled Nursing Home 9-Ambulance	O-(OL) Other Locations A-(IL) Independent Laboratory B-(ASC) Ambulatory Surgical Center

Date ___/____/___ Physician's name (print): _____ Degree: _____ Signature: _____

Address: _____ City/State: _____ ZIP: _____

Phone: (_____)_____ Individual Practitioners SS#: _____ Employer Tax ID #: _____

AUTHORIZATION

FOR OFFICIAL USE ONLY

FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ **(hospital/doctor/other Pharmacy Benefit Manager medical provider)** to disclose the following protected health information from the medical records of the patient identified below. I understand that information used or disclosed pursuant to this authorization could be subject to **re-disclosure** by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. You are hereby authorized to give to the Company specified below, or its representatives, copies of any records or data which have to do with the **physical or mental health including drug, alcohol, psychiatric, HIV infection or AIDS related treatment**. A photo static copy of this authorization shall be considered as effective and valid as the original.

Patient Name: _____ Date of Birth: _____

Social Security Number**:** _____ Date of Death: _____

Address: _____

Information to be disclosed to: Administrative Concepts, Inc or their Representative: _____

Disclose the complete records including the following information for treatment dates**:** _____ to _____**:**

☐ Admission Summary	☐ Consults	☐ Office Records	☐ Death Summary
☐ Discharge Summary	☐ X-Ray	☐ Emergency Reports	☐ Toxicology
☐ History & Physical	☐ Laboratory	☐ Operative Reports	☐ Autopsy
☐ Outpatient Reports	☐ Pathology	☐ EMS Report	☐ _____

The above information is disclosed for the purpose of processing an insurance claim.

I understand I may **revoke this authorization** at any time by requesting such of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

This authorization **expires 2 years from the date signed**; unless otherwise noted here: _____.

IMPORTANT – If patient is deceased, please INITIAL one of the statements below:

_____ I am the Administrator/Executor for the deceased & Letters of Testamentary (or comparable documents) are attached.
Initial here

_____ There is no court appointed Administrator/Executor and I am the next of kin.
Initial here

I understand that I am not required to sign this authorization. The above named health care provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

I also authorize any doctor, hospital, or other medical or medically related facility, treatment center, recovery center, insurance company, Pharmacy Benefit Manager, consumer reporting agency, employer, Social Security Administration or any other organization or person having any knowledge of the patient named above, including financial institutions, and law enforcement agencies to give Administrative Concepts, Inc or its authorized representative any information needed to determine policy claim benefits. This may include (but is not limited to) information regarding HIV antibody testing, Acquired Immune Deficiency Syndrome or related complexes, driving records, financial records, police or accident reports, mental illness and use of alcohol or drugs.

_____ _____
Signature of Legal Representative/Next of Kin/Claimant **Date**

_____ _____
Printed name of Legal Representative/Next of Kin/Claimant **Relationship or authority to act for Patient**

_____ _____
Witness **Date**

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS

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.