G·T·L

INTERCOLLEGIATE SPORTS ACCIDENT CLAIM FORM

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

COMPLETE IN DETAIL TO INSURE PROMPT HANDLING

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.

PART I- MUST BE COMPLETED BY STUDENT AND SIGNED OR CLAIM CANNOT BE PROCESSED

Name of College or University, City and State			Policy Number	
Insured's Full Name	Street Address	City	State	Zip + 4
Date of Birth	Social Security # or Student I.D. #		Male	Female

1. Give full description of injury from which you are now suffering. Tell when, where and how it happened.

2. Give exact date and time when injury occurred. Date: _____
Time: _____ am _____ pm

3. When did you first consult a physician for this condition? Date: _____

4. Have you been previously troubled with this condition? No ☐ Yes ☐ Date: _____

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- MUST BE COMPLETED BY COLLEGE OFFICIAL OR CLAIM CANNOT BE PROCESSED

Did accident occur (check yes or no)

	Yes	No
(a) While claimant was supervised?	☐	☐
(b) During Sponsored activity?	☐	☐
(c) During Programmed hours?	☐	☐
(d) On College Premises	☐	☐
(e) During Intercollegiate practice?	☐	☐
(f) During Intercollegiate competition?	☐	☐
(g) While traveling to or from a regular scheduled activity in a supervised group?	☐	☐

Time classes commence on date of injury:
_____ am _____ pm

Name of Sport: _____

Position Played: _____

Name and Title of Supervising College Official

Name _____

Title _____

I hereby certify that the statements made are correct to the best of my knowledge and belief, that the above named claimant was insured hereunder at the time of the accident, and that the above injury was sustained while participating in official activities under adequate organizational supervision on

_____ , 20 _____
DATE OF INJURY

Signature of College Official _____ Title _____ Date _____

PART III

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. _____

Dear Insured: Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. Thank you.

Arkansas	**Kansas**	**North Carolina**	**South Dakota**
California	**Louisiana**	**North Dakota**	**Texas**
Connecticut	**Massachusetts**	**Nebraska**	**Utah**
Georgia	**Michigan**	**Nevada**	**Vermont**
Iowa	**Missouri**	**Puerto Rico**	**Wisconsin**
Illinois	**Mississippi**	**Rhode Island**	**West Virginia**
	Montana	**South Carolina**	**Wyoming**

Generic Fraud Warning (to be used for above states only)
Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

Alabama - 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.

Alaska, Delaware, Idaho, Indiana, Oklahoma - 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.

Colorado, Washington D.C., Hawaii, Maine, Tennessee, Virginia - 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 coverage.

Arizona, Minnesota, New Jersey, New Mexico - Any person who knowingly and with intent to defraud an insurer presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to civil fines and criminal penalties.

Kentucky, Ohio, Oregon - Any person who intends to defraud or knowingly assists in committing a fraud against an insurer by submitting an application or claim containing a false or deceptive statement is guilty of insurance fraud.

Florida - Any person who, knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Section 817.234 F.S.

Maryland - 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.

New Hampshire - 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.

Pennsylvania - Any person who knowingly and with intent to defraud any insurance company or other person files 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.

Rhode Island - 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.

Washington State - 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.