STARR
INSURANCE COMPANIES

Accident and Medical Claim Form

Administrative Concepts, Inc.
P.O Box 4000
Collegeville, PA 19426-9000
Phone: 888.293.9229 Fax: 610.293.9299
Web: www.acitpa.com
Email: aciclaims@acitpa.com

ACI

1. Please fully complete form
2. Attach itemized bills and EOBs
3. Mail to Administrative Concepts Inc.

Policy Number:

Policy Holder:

PART I - POLICYHOLDER'S REPORT

1. Claimant's Name (Injured person)	2. Social Security Number	3. Gender	4. Date of Birth

5. Address

6. E-Mail Address	7. Phone Number (Include Area Code)

8. Claim Type: ☐ Illness ☐ Accident	9. Place where Accident Occurred	10. The injured person was a: ☐ Participant ☐ Staff Member ☐ Other ☐ Volunteer

11. Specify the Covered Class for the Injured person if applicable:

Dental Claims	12 . Indicate which Teeth were Involved in the Accident	13. Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound and Natural ☐ Filled ☐ Capped ☐ Artificial

14. Type of Injury (Indicate Part of Body Injured - e.g. broken arm, sprained ankle, etc.)

15. Describe How Accident Occurred - Give All Possible Details - Must be a Bodily Injury Due to Accident

16. Has the claimant suffered from the same or similar condition before? ☐ YES ☐ NO

17. Did the Accident Occur (Check Yes or No for Each of the following):

A.	During a policyholder program, sponsored & supervised or sanctioned activity?	☐ YES	☐ NO
B.	On activity premises?	☐ YES	☐ NO
C.	While traveling directly and uninterruptedly to or from home and the event/activity?	☐ YES	☐ NO

18. Name of Event or Activity	19. Name of Event or Activity supervisor

20. Description/Diagnosis of Illness	21. Date Symptons Began:

22. Name and Address of your regular Physician	23. Name of any Prescription Medications you are presently taking

24. Signature of Organization Representative	25. Name and Title of Organization Representative	26. Date

PART II - OTHER INSURANCE STATEMENT

Are you entitled to benefits under any other insurance policy covering this injury? ☐ YES ☐ NO
If NO, please completed the "CERTIFICATTION OF NO OTHER INSURANCE" portion on this form.

If YES, please attach copies of statements of benefits paid or denied and complete the following:
Are you eligible to receive benefits under any government plan or program including Medicare? If Yes, please explain. ☐ YES ☐ NO

Name and Address of Insurance Company	Policy Number

Name of Insured person carrying other coverage	Name of Employer providing other coverage

CERTIFICATION OF NO OTHER INSURANCE

I, _____, hereby certify that I have no other accident or health insurance or any other insurance covering this loss.

Signature of Claimant or Authorized Representative	Dated

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 TIME OF SUBMISSION.

BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE & CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I agree that a photographic copy of this Authorization shall be as valid as the original. I understand that I or my authorized representative may request a copy of this authorization. I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Signature of Claimant or Authorized Representative	Dated

IMPORTANT NOTICE

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: 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.

Arizona, Arkansas and Rhode Island: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or **specific to AR and RI:** presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Delaware: and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: 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.

Florida: and with intent to injure, defraud, or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky, New York and Pennsylvania: and with intent to defraud any insurance company or other person files an application for insurance, or files a statement of claim, containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime, **specific to PA**: subjects such person to criminal and civil penalties and specific to NY: 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.

Louisiana, New Mexico, Texas and West Virginia: presents a false or fraudulent claim for the payment of a loss (or **specific to LA, TX and W VA**: who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (or **specific to NM**: to civil fines and criminal penalties.)

Maryland: and willfully presents a false or fraudulent claim for payment of 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 Jersey: files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: with 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.

Oklahoma: 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.

Oregon: 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 hereto, may be subject to prosecution for insurance fraud.

Puerto Rico: and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

WARNING:

Colorado: 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.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maine/Washington: 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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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.

Tennessee and Virginia : It is a crime to knowingly provide false, incomplete or misleading information to an insurer or insurance company for the purpose of defrauding the insurer or insurance company. Penalties include imprisonment, fines and denial of insurance benefits.