Claim Filing Instructions

Read the instructions for the type of claim you need to file, you may have more than one.

Not sending all the documents will delay the process of your claim.

Trip Cancellation

You were unable to depart on your covered trip.

1. Complete all applicable information starting on page 2.
2. If cancellation was the result of an illness/injury, please have the patient's physician complete the "Physician's Statement" on the attached form.
3. Please submit proof of payment for claimed expenses. Acceptable forms of proof of payment include a credit card statement and/ or a copy of the front and back of the negotiated check.
4. Submit copies of the invoice/reservation for hotel, cruise, and tour bookings.
5. Submit your airline e-ticket if you have one.
6. Submit the travel supplier cancellation notice. This notice should contain the reservation/itinerary/booking information, date of cancellation, and the penalties.

If you are seeking reimbursement for payments already made, please complete the Payment Authorization Form on page 5.

Trip Interruption

You started on your trip and then had to return home due to an unforeseen event.

1. Complete all applicable information starting on page 2.
2. If the interruption was the result of an illness/injury, please have the patient's physician complete the "Physician's Statement" on the attached claim form – medical records from the date of service are applicable in lieu of a completed "Physician's Statement."
3. Please submit proof of payment for claimed expenses. Acceptable forms of proof of payment include a credit card statement and/ or a copy of the front and back of the negotiated check.
4. Submit copies of all original invoice/reservations for hotel, cruise, and tour bookings.
5. Submit your airline e-ticket (please include original and new flight itineraries).
6. If you are seeking reimbursement for payments already made, please complete the Payment Authorization Form on page 5.

Send this signed form and any accompanying documents to Administrative Concepts Inc., within 90 days from the date of service using any of the following methods:

MAIL	FAX	EMAIL
Administrative Concepts, Inc. **Attn: Claims** P.O. Box 4000 Collegeville, PA 19426-9000 USA (Allow mail 7-10 days for delivery.)	610-293-9299	ACI247@acitpa.com Email attachments can not be larger than 10 MB.

Call for help: (888)293-9229

Claim Details

1 Please select the option that best describes your participation in the covered trip Full-time employee Faculty member on a sabbatical trip Student/Participant of a Sponsored International Educational Program
2 Reason for claim *(You may check both.)* Trip Cancellation Trip Interruption

Primary Insured's Information

3 Name of Primary Insured	**4** Date of birth MM/DD/YYYY		
5 Policy number	**6** Preferred phone number		
7 Email address	**8** Fax number		
9 Mailing address (if different than home)	**10** City	**11** State	**12** Zip code
13 Home address	**14** City	**15** State	**16** Zip code
17 Preferred method of contact: Mail Email Phone			

Travel Supplier / Provider Information

18 Name of Institution (college, university, etc) in EIIA Program	**19** Phone number	**20** Confirmation/Booking number	
21 Institution mailing address	**22** City	**23** State	**24** Zip code
25 Date travel arrangements were made MM/DD/YYYY	**26** Date of initial payment for your land/sea/air arrangements MM/DD/YYYY		
27 Scheduled date of departure MM/DD/YYYY	**28** Scheduled date of return MM/DD/YYYY		
29 Actual date of return MM/DD/YYYY (trip interruption)			

Claimed Expenses

Category	Amount	Required Supporting Documents
30 Airfare	$	E-ticket receipt or original paper airline tickets
31 Lodging	$	Documents confirming your reservation/payment/partial payment
32 Other	$	Meals, taxi, any additional expenses
33 Total expenses	$	
34 Refunds	$	Examples: account credits, cash refunds, trip or meal voucher, etc.
35 Total claimed	**$**	

36 If You Are Claiming Airline Tickets, Please Complete The Below Section

Your airline tickets may have value up to one year from the original scheduled departure date. Please indicate below whether you will be exchanging your tickets for another trip. Please note: Your signature on this agreement is not a guarantee of payment. Claim determinations are subject to the terms and conditions of the plan document.

I (We) will not be using our airline ticket(s). Please enclose a copy of all electronic ticket confirmation(s).

I (We) will be exchanging our airline ticket(s) for future travel. Please enclose a copy of all electronic ticket confirmation(s) along with documentation for the cost you incurred for the exchange.

Traveling Companions

39 Companion name	**40** Certificate number
41 Companion name	**42** Certificate number
43 Companion name	**44** Certificate number
45 Companion name	**46** Certificate number

47 Reason for Cancellation / Interruption

If Cancellation / Interruption Due To Medical Reasons

48 Name of person having sickness or injury	**49** Date of birth MM/DD/YYYY
50 Relationship to Primary Insured	
51a Has the person named in question 40 received medical attention for the mentioned symptoms or illness? **Yes** **No**	**51b** If **YES**, please indicate the date you were last treated MM/DD/YYYY
52 Period of Hospitalization (if applicable) MM/DD/YYYY From:	To:

Authorization For Release Of Medical Information – To Be Completed By Patient

In order to process a claim for benefits, I authorize any physician, hospital, or other Medical Provider to release to the ACI Insurance Claims Administrator, or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed two and one-half years from the date signed. I understand I have a right to receive a copy of this authorization.

53 Date MM/DD/YYYY	**54** Signature (Signature of Person Suffering Illness or Injury or legally authorized representative)

Physician's Statement – To Be Completed By Physician Only

55 Name of doctor	**56** Office phone number		**57** Office fax number
58 Office mailing address	**59** City	**60** State	**61** Zip code
62 Name of patient	**63** Date of birth MM/DD/YYYY		
64 Diagnosis that resulted in cancellation/interruption of trip			
65 Date symptoms first appeared or accident occurred MM/DD/YYYY	**66** Date of first treatment for listed diagnosis MM/DD/YYYY		
67 Was patient treated by anyone else? **Yes** **No**	**67a** If **YES**, by whom?		**67b** If **YES**, when? MM/DD/YYYY
68 Was patient prohibited to travel due to this illness/injury? **Yes** **No**			
69 Date completed MM/DD/YYYY	**70** Physician's signature		

Documentation Requirements

71 Depending upon the circumstance involved in the loss, one or more of the following items may be required to complete the processing of your claim. Please place a check by those items you have attached. We recommend you keep copies of any items submitted with this claim.	
	Airline Ticket Stub/Receipt
	Copies of canceled checks or credit card statements with an invoice from your Travel Provider showing the date of your deposit. If you wish to waive the pre-existing condition exclusion on your claim, you must submit proof that you bought this insurance plan within 20 days of your first payment for air/land/sea arrangements.
	Police Report
	Statement from Hotel/Motel, Airline Carrier or Airport Facility that concerns your Cancellation. Note: Any cancellation of flight must be documented by the airline.
	Car Rental Agreement
	Copies of reimbursement statements issued by an airline carrier, airport facility, car rental agency, travel agent, hotel/motel or other similar establishment or any other insurance company providing reimbursement to you for the loss.
	Original purchase receipts for additional expenses
	Report from common carrier confirming cancellation
	Other (please describe)

Other Insurance / Authorization

72a Do you have any other travel or out-of-country insurance through an employer, spouse's employer, retirement plan or credit card? Yes No	72b If YES, please indicate name of insurance provider
73 Plan number	74 Telephone

I AUTHORIZE any insurance company, physician, hospital, and other health care providers, any travel organization or agency, airline carrier, rental agency, hotel, motel, or similar entity providing lodging on a rental/lease basis or any other person who may have knowledge regarding this claim, to release any information requested regarding this claim and the loss reported.

I UNDERSTAND the information obtained by use of the authorization, will be used by Administrative Concepts, Inc. to determine eligibility for benefits under this plan. Any information obtained will not be released by Administrative Concepts, Inc. to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I further authorize.

I KNOW that I may request to receive a copy of the Authorization. I AGREE that a photographic copy of this authorization is as valid as the original. I AGREE that this Authorization shall be valid for two and one half years from the date shown below. I UNDERSTAND that it is illegal to knowingly file a false or fraudulent claim or to knowingly help someone else file one. I have read and understand the Fraud Notices on page 6 of this document.

NEW YORK: 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.

75 Signature	76 Date MM/DD/YYYY

Payment Authorization Form

- To prevent any delays in claims handling, please be sure to sign this form.
- The ***Name*** in contact information must match exactly the name on the ACH, checking, or wire transfer account.
- Joint accounts require all names.

Contact Information

Name *Account Holder(s)*	Telephone		
Email address	I authorize Administrative Concepts, Inc. to contact me using this email address to discuss and/or inform me of payment confirmation. **yes** **no**		
Mailing address (P.O. boxes are not accepted)	City	State/Province/Region	ZIP/Postcode

1 Payment Type

☐ Check (check will ship to address above) ACH/EFT: US $ Canada (CAD) $ – complete section 2

☐ International Wire Transfer – complete section 3

2 U.S. Account Information

Account type: Checking Savings	Full Bank Name:		
Bank street address	City	State	Zip Code/ Postcode
ABA routing number	Account number	SWIFT BIC	

3 International/non-U.S. Account Information - Complete for payment through bank transfer outside the U.S.

Bank's full name			
Bank street address	City	State/Province/Region	Zip Code/ Postcode
Account number	Routing Number (BLZ, BSB, TRNO, branch code, etc.)		
IBAN	SWIFT BIC	Preferred reimbursement currency	
REGULATORY INFORMATION			
Bank phone number	Identification number		
	Account type: ID NIT RIF CPF CNPJ RUT CUIT OTHER		

I hereby authorize Administrative Concepts, Inc. (hereinafter COMPANY) to mail any payments to the above listed address and to deposit any amounts owed me for reimbursement of medical expenses or services rendered by initiating credit entries to my account at the financial institution (hereby BANK) indicated above. Further, I authorize BANK to accept and to credit any credit entries indicated by COMPANY to my account. In the event that COMPANY erroneously deposits funds in my account (by way of example, I am not entitled to the funds or the amount of deposit Is incorrect or such funds are deposited in the wrong account), I authorize COMPANY to debit or credit my account in the amount necessary to correct the initial deposit, but in no case shall any debit exceed the amount of the initial deposit. I further agree COMPANY is not responsible for any transaction fees charged and will release ACI of any liability in the event of lost or stolen payments.

Account holder signature	Date

Claim Form Fraud Statement - For residents of all states other than those listed below:

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.

ARIZONA: 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.

ALASKA: 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.

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

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.

FLORIDA 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.

IDAHO: 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.

KANSAS: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

KENTUCKY: 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

MARYLAND: 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.

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.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO and PENNSYLVANIA: 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 subjects such person to criminal and civil penalties.

OHIO: Any person who, 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: 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.

TENNESSEE: 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.

TEXAS: Any person who knowingly presents a 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.

VIRGINIA: 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 may have violated state law.

YOU DO NOT NEED TO RETURN THIS PAGE TO US