ACCIDENT CLAIM FORM

STARR
INSURANCE COMPANIES

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

For Customer Service, Call 888-293-9229 and Press "2".

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 A: SCHOOL AND PARENT

Policy No. _____

(1) School: _____ (2) School ID#: _____
(3) School Address: _____ (4) School Phone #_____
(5) Student: _____ (6) Student's Social Security# _____
(LAST NAME) (FIRST NAME)
Male ❑
(7) Grade:_____ (8) Birthdate_____ (9) Female ❑ (10) Date of Injury_____ (11) Time_____
(12) Where did injury occur?_____ (13) Date of first treatment_____
(14) How did injury occur?_____
(15) Part of body injured_____ (16) Type of sport_____
(17) At the time of injury was the student involved in a school sponsored & supervised activity? ❑ Yes ❑ No
(18) If athletics, designate: ❑ P.E. Class ❑ Intramural ❑ Interscholastic ❑ Practice ❑ Game
(19) Under whose supervision?_____ Was he/she a witness? ❑ Yes ❑ No
(20) Signature: X_____ Title_____ Date_____
(must be signed by school official unless injury did not occur during school activity.)

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.

PART B: PARENT OR GUARDIAN STATEMENT

(1) Student's Social Security #_____ (2) Date of first treatment_____
(3) Father's Name_____ Social Security #_____
(4) Mother's Name_____ Social Security #_____
(5) Home Address_____
(STREET) (CITY) (STATE) (ZIP) (HOME PHONE NO.)
(6) Father's Employer_____ Business Phone #_____
(7) Employer's Address_____
(8) Name and Address of other Insurance Company_____
(9) Policy No._____ ❑ Group ❑ Individual ❑ Other ❑ No Other Insurance
(10) Mother's Employer_____ Business Phone #_____
(11) Employer's Address_____
(12) Name and Address of other Insurance Company_____
(13) Policy No._____ ❑ Group ❑ Individual ❑ Other ❑ No Other Insurance

AFFIDAVIT: I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Administrative Concepts, Inc. to the extent for which Administrative Concepts, Inc. would not have been liable.

SIGN: Parent or Guardian:_____ Date_____

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

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

ITEMIZED BILLS FOR MEDICAL EXPENSES MUST BE ATTACHED

INSTRUCTIONS

1. PART A – must be completed by the school.
2. PART B – must be completed by Parent or Guardian.
3. **This plan of insurance is secondary to any health insurance you have. If you have any other insurance, submit your claim to your other insurer. When you receive their Benefit Statement, send it to ACI (at the address listed below). Attach all itemized medical bills (with diagnosis), you have received to date including this completed form. Later bills can be mailed to the insurance company separately. Please show name of school on all later bills. Please do not submit balance due, balance forward or past due statements for payment. Sending these types of statements will only delay payment, as ACI will need to request an itemized bill.**
4. Mail this report and bills within 30 days after the first treatment to:

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

Phone: 888-293-9229
Fax: 610-293-9299
Web: www.acitpa.com

The laws of some states require us to furnish you with the following notices:

WARNING Any person who knowingly
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: 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 RS! 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.