CHUBB

Request for Accident Medical Expense Benefits

MAIL TO:
Administrative Concepts, Inc.
994 Old Eagle School Road
Suite 1005
Wayne, PA 19087-1802
www.visit-aci.com
aciclaims@visit-aci.com

Group Name:

Effective Date: ____________________

Paid to Date: ____________________

Policy Number: ____________________

Benefit Amount AME: ______________

Accident Claim Form

Instructions:

1). Insured **Member** must fully complete **SECTION A**. If claim is for dependent, complete dependent section in full.
2). Claim Form must be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
3). **BALANCE DUE STATEMENTS ARE UNACCEPTABLE**. Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date(s) of service and the charge made for each service.

PLEASE MAIL COMPLETED FORM AND BILLS TO ADMINISTRATIVE CONCEPTS.

The furnishing of this form, or its acceptance by the Company, must not be constructed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A - MUST BE COMPLETED IN FULL AND SIGNED BY CLAIMANT. THERE MUST HAVE BEEN AN INJURY DUE TO A COVERED ACCIDENT IN ORDER TO BE ELIGIBLE FOR BENEFIT CONSIDERATION.

LAST NAME	FIRST	M.I.	SOCIAL SECURITY NUMBER	MEMBER ID NUMBER	DOB

ADDRESS (Street Address, PO Box, City, State, Zip Code)	PHONE NUMBER / E-MAIL ADDRESS

COMPLETE IF CLAIM IS FOR DEPENDENT:	NAME OF DEPENDENT	RELATIONSHIP TO INSURED	BIRTH DATE OF DEPENDENT

NATURE OF INJURY (Describe fully, including which part of body was injured)	DESCRIBE **HOW, WHEN, AND WHERE** ACCIDENT OCCURRED (Include date and time)
DATE FIRST TREATED BY DOCTOR	DOCTOR'S NAME
DATE LAST WORKED	DATE RETURNED TO WORK

ARE YOU ENTITLED TO BENEFITS UNDER ANY OTHER INSURANCE POLICY COVERING THIS INJURY? YES ☐ NO ☐
IF **NO**, PLEASE COMPLETE THE "CERTIFICATION OF NO OTHER INSURANCE" PORTION OF THIS FORM.
IF **YES**, PLEASE ATTACH COPIES OF STATEMENTS OF BENEFITS PAID OR DENIED AND COMPLETE THE FOLLOWING:
IS THE OTHER INSURANCE A WORKERS COMPENSATION POLICY? YES ☐ NO ☐ ARE YOU SELF-INSURED? YES ☐ NO ☐

NAME & ADDRESS OF INSURANCE COMPANY	POLICY #
NAME OF 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 Insured 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 a 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 Insured or Authorized Representative	Dated

IMPORTANT NOTICE

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 a false or fraudulent 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 many 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 Delaware Claimants: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.
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 Florida Claimants: 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 containing any false, incomplete, or misleading information, is guilty of a felony.
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 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 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.
Notice to Minnesota Claimants: A person who submits an application or 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: 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: Any person who, knowingly and with intent to defraud an insurance company or other person, submits an application or files a claim for insurance that contains any materially false information relating to an insurance company's acceptance of risk, or conceals for the purpose of misleading, information concerning any fact material to an insurance company's acceptance of risk, may be guilty of a fraudulent act, which is a crime.
Notice to Pennsylvania Claimants: 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.
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 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.