STARR
INSURANCE COMPANIES

ACI
ADMINISTRATIVE CONCEPTS, INC.
THIRD-PARTY ADMINISTRATOR

Student Accident and Sickness Medical Claim Form

1. Please fully complete form 2. Attach itemized bills and EOBs 3. Mail to Administrative Concepts, Inc.
Administrative Concepts, Inc. PO Box 4000, Collegeville, PA 19426
Phone: 888.293.9229 | Fax: 610.293.9299 | Web: www.acitpa.com | Email: aciclaims@acitpa.com

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. Email 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: (*Note: If this is a Dental Claim, please answer questions #12 and #13, otherwise skip to question #14.*)

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.

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 symptoms 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:

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Part II - Other Insurance Statement

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 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? Yes No

If yes, please explain.

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:

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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 of Account Holder(s)

Telephone Email

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 Code / 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 / Province / Region 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

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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 WVA:** 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.