CHUBB

ACE American Insurance Company
CLAIM FORM

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

COMPLETE IN DETAIL TO ENSURE PROMPT HANDLING

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

Group Plan or Program: ____________ Policyholder ____________ Policy Number ____________ Certificate/I.D. Number

Name of Insured Individual: ____________ Last Name ____________ First Name ____________ Middle Initial

Present Address: ____________ No. and Street ____________ City or Town ____________ State ____________ Zip Code Country

Home Address: ____________ No. and Street ____________ City or Town ____________ State ____________ Zip Code Country

Telephone Number: ____________ Date of Birth: ____________ Male Female (Circle One)

Date of Accident or Sickness: | Nature of Accident or Sickness:

If accident, describe fully how and where accident occurred:

If injured in play or practice of sport, indicate what sport:

Is the insured covered under any other group plan, health maintenance organization, government plan, or insurance policy?
Yes ❑ No ❑ Insurance Com[...] Number:

Are you covered as a dependent under this policy? Yes ❑ No ❑

Are you covered under your school's domestic student accident and sickness insurance plan? Yes ❑ ____________ Name of School No ❑

INSURED OR PARENT MUST SIGN BELOW:

Authorization: I hereby authorize release to Administrative Concepts, Inc., any and all information concerning advice, care or treatment provided to myself or any of my family which may be needed to process this claim.

INSURED OR PARENT MUST SIGN BELOW AUTHORIZING PAYMENT TO:

❑ Medical Provider
❑ Third Party: Name: ____________
Address: ____________
Relationship to insured: ____________

Authorization: I hereby authorize payment of medical benefits to the medical provider or third party identified on this form, for the service described.

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.

Insured's Signature: ____________ SIGN HERE
Date:

Insured's Signature: ____________ SIGN HERE
Date:

Physician or Provider Information (Please Attach Universal 1500 Form or Fill Out In Full Below)

Date of First Symptom of Illness or Injury: ____________
Date First Consulted you for This Condition: ____________
Has Patient Ever Had Same or Similar Symptoms? Yes ❑ No ❑

Diagnosis
History of Illness or Injury

Name of Referring Physician or Other Source:

For Services Related to Hospitalization (Give Date)
Admitted: ____________
Discharged: ____________

Name and Address of Facility Where Services Rendered:

Was Laboratory Work Performed Outside Your Office? Yes ❑ No ❑
Lab Charges:

Date of Service	Place of Service	CPT Code	Description of Service	ICD-9	Charge

Will You Accept Assignment?: Yes ❑ No ❑

Total Charges:

____________ SIGN HERE ____________
Providers Signature Date

Tel. #: ____________
Fax #: ____________

____
Print Providers Name Providers Address ____________

Tax I.D. # ____________

ACE 2012

PART II

Please Print All Information

Have you been covered (as an insured or dependent) by any other hospital and/or medical plan for the past 12 months?
❑ Yes ❑ No

If yes, indicate the name and address of the company ____________________

Effective date of coverage: ____________ Expiration date: ____________ Policy No. ________

Have you filed a claim with any other insurance company? ❑ Yes ❑ No

I hereby certify that the above information given by me in support of this claim is true and correct.

Patient's or Authorized Representative's Signature ____________________ Date ________

If Authorized Representative, Relationship to Patient ____________________

or Legal Designation ____________________

Please complete the following if you are insured under the medical insurance plan of a parent or spouse.

Mother's Name ____________________ Employer's Telephone # ____________

Employer's Name and Address ____________________

Name and Address of Insurance Co. ____________________

____________________ Policy No. ________

Father's Name ____________________ Employer's Telephone # ____________

Employer's Name and Address ____________________

Name and Address of Insurance Co. ____________________

____________________ Policy No. ________

Spouse's Name ____________________ Employer's Telephone # ____________

Employer's Name and Address ____________________

Name and Address of Insurance Co. ____________________

____________________ Policy No. ________

IMPORTANT NOTICE

Notice of Alabama Claimants: 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.
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 false or fraudulent information to obtain or amend insurance coverage or to make a 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 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.
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 Delaware Claimants: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.
Notice to Florida Claimants 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.
Notice to Idaho Claimants: 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. The lack of such a statement shall not constitute a defense against prosecution under this section.
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 of Louisiana 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 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 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.
Notice to Minnesota Claimants: A person who 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 Fraud Warning: 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 WARNING: Any person who, knowingly, and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud.
Notice to Pennsylvania Claimants Fraud Warning: Any person who knowingly, and with intent to defraud any insurance company or other persons 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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Notice to Rhode Island Claimants WARNING: 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 of Tennessee 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 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 of Washington 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 of West Virginia 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 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.

It is important to note that CHUBB North American Claims and the Accident & Health Division reserves its right to make changes to this language and may require additional fraud warnings incorporated onto the claim forms in the future.