How to File a Critical Illness Claim

Attached is a claim form for your Critical Illness.
Please forward claims and questions to the following address:

ACI
P.O. Box 4000
Collegeville, PA 19426-9000
800-715-4237
Fax: 610-293-9299
Business Hours 7am - 8pm EST.
www.acitpa.com

Step 1: **Submit a completed Notice of Claim (claim form) via either by mail or by facsimile.**

- Fully answer each item in Part I Claimant's Statement
- Please sign and date Authorizations section in Part II
- Read the fraud warning statement on page 4 and sign the form where indicated in Part III
- Please have the attending physician complete Part III and provide a copy of the medical records

- A fully completed Claim Form is required for each condition. Claims submitted with incomplete information will not be paid pending receipt of the missing information.

- The acceptance of a claim form by an Insurance company is not an admission of coverage. We reserve the right to obtain additional information, as needed, to evaluate the claim.

Questions? Call or Email ACI

Direct all questions regarding benefits available under the Executive Plan, claim procedures, status of a submitted claim or payment of a claim to ACI. Claim status is available by calling 800-715-4237. Select option "2" for Customer Service. Or, you may email us at ACIclaims@acitpa.com

Hours of Operation: 7am – 8pm EST, Monday through Friday

Thank you.

1. PLEASE FULLY COMPLETE THIS FORM
2. MAIL TO

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Collegeville, PA 19426-9000
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PART I – POLICYHOLDER / PATIENT INFORMATION	
Policyholder Information	**Patient Information** **Check One:** ☐ **Spouse** ☐ **Child** ☐ **Self**
Policy Number(s) Name (First, Middle, Last) ☐ Male Female	Name (First, Middle, Last) ☐ Male Female
Address (Street) Apt. #	Address (Street) Apt. #
City State Zip Code	City State Zip Code
Social Security Number **Date of Birth** / /	**Social Security Number** **Date of Birth** / /
Home Phone Number Work Phone Number ext. ( ) ( )	Home Phone Number Work Phone Number ext. ( ) ( )
ILLNESS/CONDITION INFORMATION	
What type of illness are you claiming?	When where you first treated for this illness (Date mm/dd/yy) / /
Primary Doctor Name	**Treating Doctor Name**
Address (Street)	Address (Street)
City State Zip Code	City State Zip Code
Phone Number Fax Number ( ) ( )	Phone Number Fax Number ( ) ( )

PART II – AUTHORIZATIONS

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. If not signed, please provide proof of payment.

SIGNATURE _____ **DATE** _____

If applicable, I signed on behalf of the insured as_____(indicate relationship).
If legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

SIGNATURE_____**DATE** _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to ***AXIS Insurance Company*** or its designated administrator***.*** A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse ***AXIS Insurance Company*** to the extent of any amount collectible.

I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete or misleading information may be subject to prosecution for insurance fraud (See Fraud Warning Important Notice sheet attached).

SIGNATURE_____**DATE** _____

If applicable, I signed on behalf of the insured as_____(indicate relationship).
If legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

SIGNATURE_____**DATE** _____

PART III– ATTENDING PHYSICIAN'S STATEMENT

Patient's Name (first, middle initial, last name)	Patient's Date of Birth	Patient's Address (street, city, state, ZIP code)
Patient's sex ☐ Male ☐ Female	Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child	
Date of Diagnosis:	Date first consulted you for this condition:	Has this patient previously had same or similar condition: Yes No If yes, show first treatment date(s)
Name of referring or other treating physicians	For services related to hospitalization, provide hospitalization dates Admit: Discharge:	
Name and address of facility where services rendered (if other than home or office)		
Diagnosis or nature of illness or injury:		
Physician Signature:	**Date:**	

Please check the condition that applies to this patient and provide a complete copy of the patient's medical records.

☐ Cancer	☐ Heart Attack	☐ Stroke
☐ Carcinoma in situ	☐ Heart Transplant	☐ Occupational HIV
☐ Coronary Artery Bypass Surgery	☐ Major Organ Transplant	☐ Amyotrophic Lateral Sclerosis (ALS)
☐ End Stage Renal Failure	☐ Permanent Paralysis	☐ Blindness

Important Notice

- ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia:*** 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.

- ***For Residents of Alabama:*** 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 restitution fines and confinement in prison, or any combination thereof.

- ***For residents of California***: 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.

- ***For residents of 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.

- ***For residents of the District of Columbia:*** *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.

- ***For residents of Florida:*** 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.

- ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

- ***For residents of Maine, Tennessee and 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 include imprisonment, fines and denial of insurance benefits.

- ***For residents of 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.

- ***For residents of 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.

- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

- ***For residents of New Mexico:*** 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.

- ***For residents of 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.

- ***For residents of 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.

- ***For residents of Oklahoma:*** 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.

- ***For residents of Oregon:*** Any person who knowingly and 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 may be guilty of a crime and may be subject to fines and confinement in prison.

- ***For residents of 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.

- ***For residents of Texas:*** 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.

- ***For resident of 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 false or deceptive statement may have violated state law.