Administrative Concepts, Inc.
PO Box 4000
Collegeville, PA 19426
Tel # 888-293-9229 or 610-293-9229
Fax: 610-293-9299 Email: aciclaims@acitpa.com

CLAIM FORM

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 | Member ID (Found on your insurance card)

Name of Insured: _____
Last Name | First Name | Middle Initial

Insured's DOB: _____

Insured's Gender: Male ❑■ Female ❑ Non-Binary ❑

US Home Address: _____
No. and Street | City | State | Zip Code

Abroad Address (include only if your home address is outside of the United States):
_____
No. and Street | City or Town | Zip Code | Country

Name of Parental Guardian (if Insured Person is a Minor) _____
Last Name | First Name

Contact Telephone Number:_____Best Contact Email Address: _____

Date of Accident or Sickness: _____ Date of 1st Treatment for the 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 Company:_____ Policy Number: _____

Are you covered as a dependent under this policy? No ❑ Yes ❑
If Yes, Insured's relationship to the primary policyholder _____

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

Have you filed a claim with any other insurance company for this Sickness or Injury? ❑Yes ❑No

INSURED (OR PARENTAL GUARDIAN) AFFIDAVIT AND AUTHORIZATIONS

INSURED (OR PARENT/GUARDIAN) AUTHORIZES PAYMENT TO

❑ Medical Provider

❑ Third Party: Name: _____

Address: _____

City_____ State _____ Zip code _____

Relationship to insured:_____

AFFIDAVIT: I verify that the statement on the 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 ACI to the extent for which ACI would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any health care provider, doctor, medical professional, medical facility, insurance company, person or organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment-related information concerning the patient, to ACI and its designees.

Insured or Parental Guardian Signature _____ Date _____

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.

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 and Arkansas: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or **specific to AR:** presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California , Louisiana, New Mexico and Texas : presents a false or fraudulent claim for the payment of a loss or benefit (or **specific to LA and TX:** 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.)

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.

Florida: and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing 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 fact material 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.

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.
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.

District of Columbia, 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, (or **specific to DC:** 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.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maine: 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.