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Chubb Educational Travel Claim Form

Instructions

When reporting the claim please provide your name, Policy Number, Program ID number, type of claim, and preferred contact information. Once you have completely filled out the appropriate sections of the claim form, submit it to Administrative Concepts, Inc. (contact information below). In addition to the claim form, you may be required to provide other specific information. In order to expedite your claim, please provide the applicable documentation based on the coverage(s) you are claiming.

Quick Reference Guide

- **Trip Cancellation/Interruption/Delay (complete Part A)**
  - Paid receipts for all of the following items
    - The amount of the non-refundable amounts paid for the trip:
      - Any cancellation charges
      - Any prepaid, unused, non-refundable airfare and sea or land accommodations
      - Any other reasonable additional trip expenses for travel, lodging, or scheduled events that are prepaid, unused, and non-refundable
      - The cost of a one-way economy air and/or ground transportation ticket
    - Proof of covered reason for claim
    - If applicable, include Attending Physician Statement for the individual with medical condition and complete Part C: Medical Expense

- **Lost Baggage (complete Part B)**
  - Must file a formal claim with the transportation provider and provide us with copies of all claim forms and proof that the transportation provider has paid its normal reimbursement for lost, stolen, or damaged luggage

- **Baggage Delay (complete Part B)**
  - Documentation of delay or misdirection of baggage by common carrier
  - Proof of purchase (receipts, credit card statements, etc.)

- **Medical Expense (complete Part C)**
  - An itemized bill from the treating physician
  - Prescription – receipt showing claimant’s name and the cost of the medication
  - Attending Physician’s Statement

- **Repatriation of Remains (complete Part C)**
  - Expense for embalming or cremation
  - The least costly coffin or receptacle adequate for transporting the remains
  - Cost to transport the body from place of loss to his/her home country

- **Accidental Death & Dismemberment (refer to AD&D Claim Form)**

Please Email your completed claim form with legible documentation to:

Administrative Concepts, Inc.
994 Old Eagle Road Suite 1005 • Wayne, PA 19087-1802
Email: aciclaims@visit-aci.com
All Sections need to be completed for claims submissions. Complete the Part portion specific to benefit being claimed. If you have a covered medical reason you must complete Part C and include an Attending Physician’s Statement.

I. General Information

Plan Purchased __________________________ Policy ID Number __________________________
Program ID Number __________________________
Trip Departure Date __________________________ Trip Return Date __________________________
Reason for Claim: ____________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

II. Insured Information

Primary Insured Name __________________________
Primary Insured Date of Birth __________________________
Parent or Guardian (if under 18) __________________________
Home Phone # __________________________ Work Phone # __________________________

*Please provide telephone numbers, with country and city codes.*

Email Address __________________________
Preferred Contact Method __________________________

Other Coverage Information

Do you have any other insurance? (i.e. health or homeowners insurance) □ Yes □ No
If yes, please provide source of insurance ____________________________________________

Are claim expenses recoverable from another source? □ Yes □ No
If yes, please provide details and amounts: ______________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Please Email your completed claim form with legible documentation to:

Administrative Concepts, Inc.
994 Old Eagle Road Suite 1005 • Wayne, PA 19087-1802
Email: aciclaims@visit-aci.com
III. Payment Information (funds will be issued in U.S. currency)

Payment to Insured, Guardian or Beneficiary
☐ Your home address as listed above  ☐ Direct deposit to your bank account
Name on Account ______________________________________
Bank Name _____________________________________________
Bank Address ___________________________________________
Account Number _______________________________ Account Type  ☐ Checking  ☐ Savings
Bank Routing # or Swift Code _____________________________
IBAN ______________________________________________

IV. Claim Information

Part A. Trip Cancellation / Trip Interruption / Trip Delay
☐ Trip Cancellation  ☐ Trip Interruption  ☐ Trip Delay
Date and time of incident ____________________________________
Date Trip Cancelled/Interrupted/Delayed _________________________
Reason for Claim:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Are all insureds listed on policy impacted?  ☐ Yes  ☐ No
If no, provide list of insureds impacted.
____________________________________________________________________________________
____________________________________________________________________________________
Was the cancellation/interruption a result of your own injury/sickness?  ☐ Yes  ☐ No
If yes, please fill out Part C.

Was the cancellation/interruption a result of injury/sickness to a relative or person defined in the Policy?  ☐ Yes  ☐ No
If yes, please fill out the below and Part C.

Name _______________________________ Relationship to you ___________________________
Address _____________________________________________________________________________
If claiming Trip Delay, how long was your delay? ________________________________
Please provide all documentation supporting the reason for your Trip Cancellation/Interruption/Delay.

Please Email your completed claim form with legible documentation to:

Administrative Concepts, Inc.
994 Old Eagle Road Suite 1005 • Wayne, PA 19087-1802
Email: aciclaims@visit-aci.com
Part A. Trip Cancellation / Trip Interruption / Trip Delay (continued)

Chart of Claimed Expenses (Please provide receipts supporting the below expenses)

<table>
<thead>
<tr>
<th>Type of Expense</th>
<th>Name of Individual Associated with Expense</th>
<th>Date of Expense</th>
<th>Receipts Attached</th>
<th>Expense Amount</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Total Sum Claimed

Part B. Lost Baggage/Baggage Delay

☐ Lost Baggage  ☐ Baggage Delay

Date of loss / damage / theft _______________________________________________________

Country where loss / damage / theft occurred _______________________________________

Details of loss / damage / theft ___________________________________________________

To whom was loss / damage / theft reported _________________________________________

If article(s) lost/stolen, what steps were taken regarding recovery of article(s)? (Provide any written evidence)

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

If article(s) damaged, please supply estimates for cost of repairs or a letter from a reputable dealer confirming irreparably damaged. (Supply receipts: if not available, please supply replacement estimates/invoices)

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Please Email your completed claim form with legible documentation to:

Administrative Concepts, Inc.
994 Old Eagle Road Suite 1005 • Wayne, PA 19087-1802
Email: aciclaims@visit-aci.com
Part B. Lost Baggage/Baggage Delay (continued)

Is any property lost/damaged/stolen insured by another company? □ Yes □ No
If yes, please supply name, address, telephone number, and policy number.
____________________________________________________________________________________
____________________________________________________________________________________

Please supply name, address telephone number, and policy numbers of homeowners/household contents insurers.
____________________________________________________________________________________
____________________________________________________________________________________

Have you ever had any previous claims on this type of insurance? □ Yes □ No
If yes, please supply details with relevant dates.
____________________________________________________________________________________
____________________________________________________________________________________

Particulars of Claim

<table>
<thead>
<tr>
<th>Full Description of Each Item of Property Lost, Damaged, or Stolen</th>
<th>State to Whom Property Belonged</th>
<th>Date of Purchase</th>
<th>Original Purchase Price</th>
<th>Receipts/Replacement Estimates Attached</th>
</tr>
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Total Sum Claimed

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Part C. Medical Expense & Repatriation of Remains

Patient's Name ______________________________________ Date of Illness (first symptom) or injury ____________

Relationship to the Primary Insured ________________________________________________________________

Diagnosis or nature of illness or injury _____________________________________________________________

If injury – please describe _______________________________________________________________________

__________________________________________________________________________________________

Date first consulted for this condition ________________________________

Hospital Confinement Dates  From __________ To __________

Disability Dates  Total: From __________ To __________ Partial: From __________ To __________

Place of Service __________________________________________________________

Treating Doctor(s) ________________________________________________________________

Treating Doctor City, State ____________________________________________________________________

Primary Care Physician (PCP) ________________________________________________________________

PCP City, State _______________________________ PCP Phone # _________________________________

Include copy of Attending Physician Statement with documentation.

Please Email your completed claim form with legible documentation to:

Administrative Concepts, Inc.
994 Old Eagle Road Suite 1005 • Wayne, PA 19087-1802
Email: aciclaims@visit-aci.com
V. Declaration

I declare that the information given is to the best of my knowledge and belief, full, true, and correct:

Signed _____________________________________ Dated _______________________________

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.

Signature of Insured or Authorized Representative

___________________________________________________________

Relationship (if other than Insured) ________________________________________________________

Dated __________

Address _____________________________________________________________________________

Patient’s Signature and Release (Parent or Guardian, if claim is for a minor), I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine claim payment.

Signed _____________________________________ Dated _______________________________

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Email: aciclaims@visit-aci.com
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**Generic 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.

**The following states have required us to use state specific language as follows:**

**Alaska**  
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.

**California**  
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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of risk or the hazard assumed by the insurer.

**Florida**  
Any person who knowingly and with intent to injure, defraud, or deceive an 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.

**Louisiana**  
Any person who knowingly presents a false or fraudulent claim for payment or 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.

**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 of insurance is guilty of a crime and may be subject to fines and confinement in prison.

**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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

**Ohio**  
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.

**Oklahoma**  
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the process of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon**  
Any person with the intent to knowingly 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 that is related to the acceptance of the risk by the insurer, may be guilty of insurance fraud and may be subject to prosecution.

---

**Please Email your completed claim form with legible documentation to:**

Administrative Concepts, Inc.  
994 Old Eagle Road Suite 1005 • Wayne, PA 19087-1802  
Email: aciclaims@visit-aci.com
Pennsylvania
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 and subjects such person to criminal and civil penalties.

Virginia
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application containing any material misstatement, or files a claim containing a false or deceptive statement may have violated state law.
Chubb Educational Travel Claim Form

Attending Physician Statement

Section A. Insured Information

Plan Purchased: _______________________________  Policy Number: ________________________________
Reason for claim: __________________________________________________________________________
Name:  ______________________________________  Date of Birth: _________________________________
Parent or Guardian (if under 18): ____________________
Home Address: ____________________________________________________________________________
Home #:  ____________________________________  E-mail: ______________________________________

Section B. Medical Information (To be completed by Physician Rendering Treatment)

Patient’s Name: ________________________________
Diagnosis: _______________________________________________________________________________
Date symptoms or injury first occurred: __________________
Date first consulted for this condition: __________________
Has the patient ever had the same or similar condition? □ Yes □ No
If Yes, please provide the date of the condition: __________
Did you advise the trip to be cancelled due to the patient’s medical condition? □ Yes □ No
If Yes, please provide details: ___________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Does the patient’s condition render them totally or partially disabled? □ Yes □ No
If Yes, Disability dates: Total: From __________ To __________  Partial: From __________ To __________
Was patient able to return to work? □ Yes □ No
If Yes, Return to Work Date: _______________________
If patient Hospital Confined, Hospital confinement dates: From __________ To __________
Hospital Name: ____________________________________________________________________________

Section C. Declaration

I declare that the information given is to the best of my knowledge and belief, full, true and correct:

Physician Signature ____________________________ Dated ________________________________

I declare that the information given is to the best of my knowledge and belief, full, true and correct:

Signature of Insured or Authorized Representative ______________________________
Relationship (if other than Insured) __________________________ Dated ________________________________
Address _____________________________________________________________

Please Email your completed claim form with legible documentation to:

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994 Old Eagle Road Suite 1005 • Wayne, PA 19087-1802
Email: aciclaims@visit-aci.com
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**The following states have required us to use state specific language as follows:**

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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.

**California**
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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of risk or the hazard assumed by the insurer.

**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.

**Louisiana**
Any person who knowingly presents a false or fraudulent claim for payment or 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.

**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 of insurance is guilty of a crime and may be subject to fines and confinement in prison.

**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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

**Ohio**
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.

**Oklahoma**
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the process of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon**
Any person with the intent to knowingly 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 that is related to the acceptance of the risk by the insurer, may be guilty of insurance fraud and may be subject to prosecution.

---

**Please Email your completed claim form with legible documentation to:**

Administrative Concepts, Inc.
994 Old Eagle Road Suite 1005 • Wayne, PA 19087-1802
Email: aciclaims@visit-aci.com
**Pennsylvania**
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 and subjects such person to criminal and civil penalties.

**Virginia**
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application containing any material misstatement, or files a claim containing a false or deceptive statement may have violated state law.
Chubb Educational Travel
Accidental Death & Dismemberment Claim Form

Instructions
When reporting the claim please provide your name, Program ID number, type of claim, and mailing address to send the claim. Once you have completely filled out the appropriate sections of the claim form, it must be remitted back to Administrative Concepts, Inc. In addition to the claim form, there may be specific information required. In order to expedite your claim, please provide the applicable documentation based on the coverage(s) you are claiming listed below:

Accidental Death:
☐ Certified copy of the final death certificate
☐ Police report, any autopsy report, any medical records or reports, and any newspaper clippings
☐ Travel itinerary

Accidental Dismemberment:
☐ Police report, all medical records, any eyewitness statements and complete accident details
☐ Travel itinerary

Please Email your completed claim form with legible documentation to:

Administrative Concepts, Inc.
994 Old Eagle Road Suite 1005 • Wayne, PA 19087-1802
Email: aciclaims@visit-aci.com
Section A. Trip Information

Plan Purchased: ___________________________________ Policy Number: ____________________________
Program ID Number: _______________________________ Date of Booking: ____________________________
Trip Departure Date: ________________________________ Trip Return Date: ____________________________
Reason for claim: ____________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Section B. Insured Information

Primary Insured Name: ______________________________ Primary Insured Date of Birth: _________________
Parent or Guardian (if under 18): _______________________________________________________________
Home Address: ______________________________________________________________________________
Please provide telephone and facsimile numbers, with country and city codes.
Home #: ______________________________________ Work #: ______________________________________
Fax #: ______________________________________ E-mail: _________________________________

Other Coverage Information
Do you have any other insurance? □ Yes □ No
If yes, please provide source of insurance: _________________________________________________________
__________________________________________________________________________________________
Are claim expenses recoverable from another source? □ Yes □ No
If yes, please provide details and amount: _________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Section C. Payment Information (funds will be issued in U.S. Currency)

Payment to Insured, Guardian or Beneficiary.
□ Your home address as listed above  □ Direct deposit to your bank account

Name on account: ____________________________________________________________________________
Bank Name: _________________________________________________________________________________
Bank Address: ________________________________________________________________________________
Account #: __________________________ Bank Routing # or Swift Code: _____________________________
IBAN: ______________________________________________________________________________________

Please Email your completed claim form with legible documentation to:

Administrative Concepts, Inc.
994 Old Eagle Road Suite 1005 • Wayne, PA 19087-1802
Email: aciclaims@visit-aci.com
Section D. Accidental Injury or Death (see list of required documents on page 1)

Name: __________________________________________ Date and time of accident: ____________________

Give details of the accident: ___________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Name and addresses of witnesses to accident:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Diagnosis: ______________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

If loss is sight, is loss in both eyes? □ Yes □ No
If loss is hearing, is loss in both ears? □ Yes □ No
If loss is speech, is loss total and irreversible? □ Yes □ No

If loss is extremity, where is severance? _____________________________

Was the loss caused by an accident independent of all other causes? □ Yes □ No
Was the loss caused in any way by illness? □ Yes □ No

If yes, list dates you received treatment for this illness: _______________________________________

Please Email your completed claim form with legible documentation to:

Administrative Concepts, Inc.
994 Old Eagle Road Suite 1005 • Wayne, PA 19087-1802
Email: aciclaims@visit-aci.com
Name and addresses of all physicians consulted

Primary Care Physician: ____________________________________________

PCP City: ___________________________ PCP State: _______ PCP Phone#: ______________________

Name: ____________________________________ Date of treatment: _________________________

Address: _______________________________________________________________________________

Name: ____________________________________ Date of treatment: __________________________

Address: _______________________________________________________________________________

What operation was performed? ______________________________________________________________

If in a hospital, which one: From _________ To __________

If accident resulted in death, please fill out the below information:

Was there a judicial ruling made on the cause of death by a judge or jury? ☐ Yes ☐ No

If yes, please complete the following and attach a copy of the proceedings and verdict.

Name of person conducting autopsy: _____________________ Title: ________________________________

Address: _______________________________________________________________________________

First physician attending deceased after injury

Name: _________________________________________________________________________________

Address: _______________________________________________________________________________

Previous medical history

Primary Care Physician: ____________________________________________

PCP City: ___________________________ PCP State: _______ PCP Phone#: ______________________

Was deceased treated for any medical conditions within 5 years prior to accident? ☐ Yes ☐ No

If yes, please list physician(s) in attendance below.

Name: _______________________________________________________________________________

Medical condition: ______________________________________________________________________

Dates of treatment: _____________________________________________________________________

Address: ______________________________________________________________________________

Name: _______________________________________________________________________________

Medical condition: ______________________________________________________________________

Dates of treatment: _____________________________________________________________________

Address: ______________________________________________________________________________

Please Email your completed claim form with legible documentation to:

Administrative Concepts, Inc.
994 Old Eagle Road Suite 1005 • Wayne, PA 19087-1802
Email: aciclaims@visit-aci.com
To be completed if death resulted from motor vehicle accident:

Type of Vehicle: ___________________________________ Registered Owner: ___________________________________

Was the deceased the driver?  ☐ Yes  ☐ No

Use of vehicle:  ☐ Business  ☐ Pleasure  ☐ Business and Pleasure

Name of law enforcement agency investigating accident: _________________________________________________

Address: _______________________________________________________________________________

Section E. Declaration

I declare that the information given is to the best of my knowledge and belief, full, true and correct:

Signed ___________________________________ Dated _______________________________

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.

Signature of Insured or Authorized Representative _________________________________________________

Relationship (if other than insured) ________________________________ Dated ________________________________

Address ____________________________________________________________________________________

Patient’s Signature and Release (Parent or Guardian, if claim is for a minor)

I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine claim payment.

Signature ____________________________________ Dated ________________________________

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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.

**California**
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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of risk or the hazard assumed by the insurer.

**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.

**Louisiana**
Any person who knowingly presents a false or fraudulent claim for payment or 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.

**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.

**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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

**Ohio**
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.

**Oklahoma**
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the process of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon**
Any person with the intent to knowingly 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 that is related to the acceptance of the risk by the insurer, may be guilty of insurance fraud and may be subject to prosecution.

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Please Email your completed claim form with legible documentation to:

Administrative Concepts, Inc.
994 Old Eagle Road Suite 1005 • Wayne, PA 19087-1802
Email: aciclaims@visit-aci.com
Pennsylvania
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 and subjects such person to criminal and civil penalties.

Virginia
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application containing any material misstatement, or files a claim containing a false or deceptive statement may have violated state law.

Please Email your completed claim form with legible documentation to:

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