MAIL TO:
Administrative Concepts, Inc.
PO Box 4000 Collegeville, PA 19426
aciclaims@acitpa.com

Underwritten by **United States Fire Insurance Company**

Accidental Death & Dismemberment Claim Form

When reporting the claim please provide your name, Policy 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 (if Applicable)

Accidental Dismemberment:

- Police report, all medical records, any eyewitness statements and complete accident details
- Travel itinerary (if Applicable)

Please Email your completed Claim Form with itemized bills and receipts to:
(to expedite your claim, please send with legible receipts)

Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426-4000
(888) **585-9033**
ACIclaims@acitpa.com

Section A. Policyholder Information

Primary Policyholder Policy#:

Member ID:

Primary Policyholder Name: _____

Primary Policyholder: Phone Number:

Trip Departure Date:_____ Trip Return Date:_____

Section B. Claimant Information

Claimant Name: _____Claimant Date of Birth: _____

Name of Parent or Guardian of Claimant (if under 18):

Home Address:

Phone Number

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 ◯ Other Address

If Other, Address _____

Apt or Suite#: _____

City and State: _____

Zip Code: _____

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: _____

Name and addresses of all physicians/hospitals consulted

Physician Name : _____

Address:_____ State: _____ Phone #: _____

Hospital Name: _____ Date of treatment:_____

Address: _____

Name: _____ Date of treatment: _____

Address: _____

What operation was performed? _____

_____

If accident ***resulted in death, please fill out the below information:*** ◯ Yes ◯ No

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 a 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: _____

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 Primary Policyholder or Claimant: _____

Relationship to Primary Policyholder: _____ Dated: _____

Primary Policyholder Email 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: _____ Date _____

(The following verification section is required to be completed if you are submitting the claim and are not the primary Policyholder)

Verification from the Primary Policyholder

Please confirm the following information regarding your recent travels:

Primary Policyholder First Name followed by Last name:
_____

Dates of Travel (Start and End Date): _____

Primary Policyholder Signature: _____

Date: _____

(A full response to the above is required for the verification of the claim. Without verification, the claim cannot be considered completed for review and processing by ACI)

IMPORTANT NOTICE

Notice to Claimants and Primary Policyholders: 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.

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P.O. Box 4000
Collegeville, PA 19426-4000
www.acitpa.com 888-**585-9033**

FRAUD WARNING STATEMENT

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW: 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.

ARIZONA: 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.

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: For your protection California law requires the following to appear on this form: 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.

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.

FLORIDA 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.

IDAHO: 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.

KANSAS: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

KENTUCKY:
Application: 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.
Claim Form: 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

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 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.

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.

NEW MEXICO and 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.

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.

OKLAHOMA: 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.

TENNESSEE: 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.

TEXAS: Any person who knowingly presents a 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.

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 claim containing a false or deceptive statement may have violated state law.

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.

Employee Signature _____ Date _____

*The fraud warning in NY must appear above the signature line.