

**Administrative Concepts, Inc.**

P.O. Box 4000

Collegeville, PA 19426-9000

Phone: 888-293-9229 Fax: 610-293-9299

Web: www.visit-aci.com

**Policy Number:** \_\_\_\_\_**Policy Holder:** \_\_\_\_\_**ACE American Insurance Company**

1. PLEASE FULLY COMPLETE FORM
2. ATTACH ITEMIZED BILLS AND EOBs
3. MAIL TO ADMINISTRATIVE CONCEPTS INC.

**PART I - POLICYHOLDER'S REPORT**

1. Claimant's Name (Injured person)		2. Social Security Number	3. Gender	4. Date of Birth
5. Address				
6. E-Mail Address		7. Phone Number (Include Area Code)		
8. Date and Time of Accident	9. Place where Accident Occurred		10. The injured person was a: <input type="checkbox"/> Participant <input type="checkbox"/> Staff Member <input type="checkbox"/> Other <input type="checkbox"/> Volunteer	
11. Specify the Covered Class for the Injured person if applicable:				
Dental Claims	12. Indicate which Teeth were Involved in the Accident	13. Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial		
14. Type of Injury (Indicate Part of Body Injured - e.g. broken arm, sprained ankle, etc.)				
15. Describe How Accident Occurred - Give All Possible Details - Must be a Bodily Injury Due to Accident				
16. Has the claimant suffered from the same or similar condition before?			<input type="checkbox"/> YES <input type="checkbox"/> NO	
17. Did Accident Occur (Check Yes or No for Each of the Following):				
A. During a policyholder program, sponsored & supervised, or sanctioned activity?			<input type="checkbox"/> YES <input type="checkbox"/> NO	
B. On activity premises?			<input type="checkbox"/> YES <input type="checkbox"/> NO	
C. While traveling directly and uninterruptedly to or from home and the event/activity?			<input type="checkbox"/> YES <input type="checkbox"/> NO	
18. Name of Event or Activity		19. Name of Event or Activity supervisor		
20. Signature of Organization Representative		21. Name and Title of Organization Representative		22. Date

**PART II - OTHER INSURANCE STATEMENT**

Are you entitled to benefits under any other insurance policy covering this injury? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If NO, please complete the "CERTIFICATION OF NO OTHER INSURANCE" portion on this form.	
If YES, please attach copies of statements of benefits paid or denied and complete the following .	
Are you eligible to receive benefits under any governmental plan or program, including Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, Please explain:	
Name & Address of Insurance Company	Policy #
Name of insured person carrying other coverage	Name of Employer providing other coverage

**CERTIFICATION OF NO OTHER INSURANCE**

I, _____, hereby certify that I have no other accident or health insurance or any other insurance covering this loss.	
Signature of Claimant or Authorized Representative	Dated

*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.*

**PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE UNLESS A PAID RECEIPT IS ATTACHED AT TIME OF SUBMISSION.****BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE & CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF****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. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Signature of Claimant or Authorized Representative	Dated
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## IMPORTANT NOTICE

**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 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 Delaware Claimants:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.

**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 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 containing any false, incomplete, or misleading information, is guilty of a felony.

**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 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 submits an application or 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 material 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 person 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 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 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.