CLAIM FILING PROCEDURE

NOTIFICATION OF INJURY OR SICKNESS MUST BE PROVIDED WITHIN 30 DAYS AFTER THE DATE OF ACCIDENT OR COMMENCEMENT OF SICKNESS. BILLS MUST BE SUBMITTED WITHIN 30 DAYS OF THE DATE OF TREATMENT.

- The front side of this claim form, PART 1, must be completed and signed **by the insured.** Answer **all** questions.
- PART II, must be completed and signed **by the insured.**
- Attach itemized bills indicating the date of treatment, type of service rendered and charge for each. Return the completed claim form and itemized bills to ACI, Suite 215, 997 Old Eagle School Rd., Wayne, PA 19087-1706. Keep a copy for your records.

Incomplete claim forms will result in a processing delay. Correspondence from the claims department should be handled promptly. Allow up to 2 weeks for processing.

Only one claim form need be completed at the beginning of treatment for each condition. Subsequent bills for follow-up treatment should be submitted separately identifying your name, policy number, school and indicating that it is for a claim already submitted.

(Detach & Save) (OVER)

GUARANTEE TRUST LIFE INSURANCE COMPANY

MAIL TO:
Administrative Concepts, Inc.
997 Old Eagle School Road
Suite 215
Wayne, PA 19087-1706
www.visit-aci.com

BOTH SIDES OF CLAIM FORM MUST BE COMPLETED AND RETURNED WITHIN 30 DAYS. COPIES OF ITEMIZED BILLS MUST BE ATTACHED

Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act. For residents of the following states, please see the reverse side: *Colorado, Florida, Maryland, New Jersey, New York, Pennsylvania, Oregon, Virginia, District of Columbia, Tennessee, Nevada or Texas.*

❏ GRADUATE
❏ UNDERGRADUATE

- PLEASE PRINT ALL INFORMATION -

PARTS I & II - MUST BE COMPLETED AND SIGNED BY STUDENT

Name of College or University, City and State | Domestic ❏ International ❏ | Policy Number | Birth Date

Insured Student's Name ____________________
LAST NAME FIRST NAME M.I. SOCIAL SECURITY # PHONE#

Present Address ____________________
NO. AND STREET CITY OR TOWN STATE ZIP # + 4

Home Address ____________________
NO. AND STREET CITY OR TOWN STATE ZIP # + 4

If claim for dependent, give dependent's name ____________, relationship to Insured ____________Age ______

COMPLETE THIS SECTION FOR ACCIDENT CLAIM

Exact nature of injury ____________________

Date and hour of occurrence ____________________

Was the injury due to practice or play of a sport? ❏ Yes ❏ No

Which sport? ____________________

❏ Intercollegiate ❏ Intramural ❏ Club ❏ Other

Is condition work related? ❏ Yes ❏ No

Is condition due to auto accident ❏ Yes ❏ No

If yes, please attach detailed policy information on all motor vehicles involved in accident.

Were you treated in the Health Service for this condition? ❏ Yes ❏ No

Seen by: ____________ Date: ____________

If your claim is for services outside of the Health Service, were you referred? ❏ Yes ❏ No

If not, why? Away from school ❏
For what reason: ____________________

COMPLETE THIS SECTION FOR SICKNESS CLAIM

Date of sickness ____________________

Date symptoms first noticed ____________________

If pregnancy, date of last menstrual period ____________________

What is the exact nature of the sickness? ____________________

Have you ever had the same or similar condition? ❏ Yes ❏ No

If yes, date of first treatment ____________________

Date of last treatment ____________________

Were you treated in the Health Service for this condition? ❏ Yes ❏ No

Seen by: ____________ Date: ____________

If your claim is for services outside of the Health Service, were you referred? ❏ Yes ❏ No

If not, why? Away from school ❏
For what reason: ____________________

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.

To any medical care provider, medical care facility, Insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Administrative Concepts, Inc. or the underwriting company. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The Company will use this information to determine if my claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigative or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization. I certify that the information given by me in support of my claim is true and correct.

Patient's or Authorized Representative's Signature ____________________ Date____________

If Authorized Representative, Relationship to Patient ____________________

or Legal Designation ____________________
STREET CITY STATE ZIP CODE + 4

For your future reference, please keep the following information, with a copy of each bill submitted for payment.

NAME OF MEDICAL PROVIDER	DATE OF SERVICE	AMOUNT OF CHARGE	DAY MAILED TO ACI

(Detach & Save)

PART II

Please Print All Information

Have you been covered (as an insured or dependent) by any other hospital and/or medical plan for the past 12 months?

❑ Yes ❑ No

If yes, indicate the name and address of the company ______________________________

Effective date of coverage: ____________ Expiration date: ____________ Policy No. ________

Have you filed a claim with any other insurance company? ❑ Yes ❑ No

I hereby certify that the above information given by me in support of this claim is true and correct.

Patient's or Authorized Representative's Signature ______________________ Date ________

If Authorized Representative, Relationship to Patient ______________________________

or Legal Designation ______________________________

The following section may not be applicable to you if you are not covered under any other medical insurance plan.

Mother's Name ______________________ Employer's Telephone # ______________

Employer's Name and Address ______________________________

Name and Address of Insurance Co. ______________________________

______________________________ Policy No. ________

Father's Name ______________________ Employer's Telephone # ______________

Employer's Name and Address ______________________________

Name and Address of Insurance Co. ______________________________

______________________________ Policy No. ________

Spouse's Name ______________________ Employer's Telephone # ______________

Employer's Name and Address ______________________________

Name and Address of Insurance Co. ______________________________

______________________________ Policy No. ________

IMPORTANT CLAIM NOTICE

Colorado Residents: 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 Residents: 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.

Maryland Residents: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: 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 $5000 and the stated value of the claim for each such violation.

Pennsylvania Residents: 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.

Oregon Residents: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

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

District of Columbia Residents: 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.

Tennessee Residents: 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.

Nevada Residents: Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Texas Residents: 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.