**INTERCOLLEGIATE SPORTS ACCIDENT CLAIM FORM**

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

**COMPLETE IN DETAIL TO INSURE PROMPT HANDLING**

**Beech Street**

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. Please see reverse side..

*- PLEASE PRINT ALL INFORMATION -*

## PART I - MUST BE COMPLETED BY STUDENT AND SIGNED OR CLAIM CANNOT BE PROCESSED

| Name of College or University, City and State | | Policy Number | |
|---|---|---|---|
| Insured's Full Name | Street Address | City | Zip + 4 |
| Date of Birth | Social Security # or Student I.D. # | ❑ Male ❑ Female | |

1. Give full description of injury from which you are now suffering. Tell when, where and how it happened.

2. Give exact date & time when injury occurred. Date: ____________ Time: ________ am ________ pm

3. When did you first consult a physician for this condition? Date: ____________

4. Have you been previously troubled with this condition? ❑ No ❑ Yes 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.***

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. 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

## PART II - MUST BE COMPLETED BY COLLEGE OFFICIAL OR CLAIM CANNOT BE PROCESSED

Did accident occur (check yes or no)

| | Yes | No |
|---|---|---|
| (a) While claimant was supervised? | ( ) | ( ) |
| (b) During sponsored activity? | ( ) | ( ) |
| (c) During programmed hours? | ( ) | ( ) |
| (d) On College premises? | ( ) | ( ) |
| (e) During intercollegiate practice? | ( ) | ( ) |
| (f) During intercollegiate competition? | ( ) | ( ) |
| (g) While traveling to or from a regular scheduled activity in a supervised group? | ( ) | ( ) |

Time classes commence on date of injury:
________ am ________ pm

Name of sport: ________

Position played ________

Name & Title of Supervising College Official

Name ________

Title ________

I hereby certify that the statements made are correct to the best of my knowledge and belief, that the above named claimant was insured hereunder at the time of the accident, and that the above injury was sustained while participating in official activities under adequate organizational supervision on

________________________ , 20 ____
DATE OF INJURY

Signature of College Official ________________ Title ________________ Date ________

ICS-07

# 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 is applicable if you are 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**

**California 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.

**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.

**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.

**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.

**Maine/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.

**Maryland/Oregon Residents:** 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 may be guilty of insurance fraud.

**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.

**New Hampshire Residents:** 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 R.S.A.638.20.

**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.

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

**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.

**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.

**Virginia Residents:** 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 may have violated state law.