



**ZURICH**

**ZURICH AMERICAN INSURANCE COMPANY  
BLANKET ACCIDENT INSURANCE POLICY  
PROOF OF COVERED LOSS FORM  
Mail claims to:**

Administrative Concepts, Inc.  
994 Old Eagle School Road  
Suite 1005  
Wayne, PA 19087-1802  
[www.visit-aci.com](http://www.visit-aci.com)

***For Customer Service, Call 888-293-9229 and Press "2"***

**INSTRUCTIONS**

This form must be completed in full and submitted within ninety (90) days of the accident or injury.

Part A – MUST be completed by the School.

Part B – MUST be completed by the Parent or Guardian.

**PARENTS' INSTRUCTIONS FOR FILING A CLAIM:**

The Accident Insurance coverage purchased by your School District or Arch Diocese provides coverage on an EXCESS BASIS only. This means that only the medical expenses NOT payable by your own personal or group insurance are eligible for coverage under this policy, up to the policy limits. Please follow these instructions below when filing a claim:

1. IMMEDIATELY submit a claim for all medical expenses to the company that administers your personal or group insurance (including Major Medical coverage). If you have coverage through an HMO or a similar organization, you must comply with their requirements or your claim will not be covered under this policy.
2. After your primary insurance has paid the medical expenses up to the policy limits, submit Itemized Bills (CMS-1500 from physicians and UB-04 from hospitals) AND copies of the Explanation of Benefits from your primary insurance company as you receive them and mail to the address shown below. We cannot accept balance due bills.
3. Please write the claimant's name, policy number, and date of accident on all Bills and Explanation of Benefits.
4. Please keep a copy of this Claim Form, all bills, and primary insurance Explanation of Benefits for your own records.
5. If you need further information, call 888-293-9229 or contact us by the information below:

**Administrative Concepts, Inc.  
994 Old Eagle School Road, Suite 1005  
Wayne, PA 19087-1802**

**Phone: 888-293-9229  
Fax: 610-293-9299  
Web: [www.visit-aci.com](http://www.visit-aci.com)**

**PART A: SCHOOL DISTRICT OR DIOCESE**

- 1. Policy Number: MCB 5465727
- 2. School: Durham Public School
- 3. School Address: \_\_\_\_\_
- 4. School Phone: \_\_\_\_\_
- 5. Student: \_\_\_\_\_
- 6. Grade: \_\_\_\_\_
- 7. Birthdate: \_\_\_\_\_
- 8. Male:  Female:
- 9. Date of Injury: \_\_\_\_\_
- 10. Time: \_\_\_\_\_
- 11. Where did the Injury occur: \_\_\_\_\_
- 12. Date of first treatment: \_\_\_\_\_
- 13. How did the Injury occur: \_\_\_\_\_
- 14. Part of body injured: \_\_\_\_\_
- 15. Activity: \_\_\_\_\_
- 16. At the time of the injury was the student involved in a school sponsored and supervised activity?  Yes  No
- 17. If athletics, designate:  Intramural  Interscholastic  Practice  Game
- 18. Under whose supervision? \_\_\_\_\_ Was he/she a witness?  Yes  No
- 19. Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
(must be signed by school official)

**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.**

**PART B: PARENT OR GUARDIAN STATEMENT**

- 1. Father's/Guardian's Name: \_\_\_\_\_ DOB: \_\_\_\_\_
- 2. Mother's/Guardian's Name: \_\_\_\_\_ DOB: \_\_\_\_\_
- 3. Home address: \_\_\_\_\_  
(Street) (City) (State) (Zip) (Home phone #)
- 4. Father's/Guardian's Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_
- 7. Employers address: \_\_\_\_\_  
(Street) (City) (State) (Zip)
- 8. Name and Address of Medical/Health Insurance Company: \_\_\_\_\_
- 9. Policy No. \_\_\_\_\_  Group  Individual  Other  No Insurance
- 10. Mother's/Guardian's Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_
- 11. Employers address: \_\_\_\_\_  
(Street) (City) (State) (Zip)
- 12. Name and Address of Medical/Health Insurance Company: \_\_\_\_\_
- 13. Policy No. \_\_\_\_\_  Group  Individual  Other  No Insurance

**ACKNOWLEDGMENT:** I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Administrative Concepts, Inc. to the extent for which Administrative Concepts, Inc. would have been liable. I acknowledge and have reviewed the applicable fraud warnings shown below.

Signature: Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

PAYMENT WILL BE MADE TO THE PROVIDER OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS) UNLESS PROOF OF PAYMENT OR PAID RECEIPT IS ATTACHED.

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 or to Administrative Concepts, Inc. or Zurich American Insurance Company, its affiliates, employees, agents or authorized representatives ("Zurich"), the underwriting company providing insurance. 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. ACI and Zurich will use this information to determine if my claim is eligible and to evaluate and determine the coverage for this claim. Any information obtained will not be released by ACI or Zurich except to my primary health insurance carrier (if any) or persons or organizations performing investigative or legal services for ACI or Zurich 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 understand that I have the right to revoke this authorization at any time by writing to Administrative Concepts, Inc. I know I have a right to receive a copy of this authorization upon request.

Claimant's or Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If Parent/Guardian, Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
(Street) (City) (State) (Zip code + 4)

## FRAUD WARNING NOTICES

Any person who knowingly and with intent to defraud any insurance company or another 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 the person to criminal and civil penalties. (Not applicable in AL, AR, CO, DC, FL, KS, KY, LA, MD, ME, NJ, NM, NY, OH, OK, OR, PA, PR, RI, TN, TX, VA, VT, WA, and WV.)

In **Arkansas, Louisiana, Rhode Island, or West Virginia**: 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.

In **Alabama**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

In **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.

In **District of Columbia**: 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.

In **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.

In **Kansas**: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to an insurer, purported insurer, or to or by a broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act and may be subject to criminal and/or civil fines or penalties.

In **Kentucky**: 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.

In **Maine, Tennessee, Virginia, or Washington**: 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.

In **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.

In **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.

In **New Mexico**: 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.

In **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.

In **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.

In **Oklahoma**: **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.

In **Oregon**: Any person who knowingly and with intent to defraud any insurer or other person files an application for insurance or statement of claim containing any materially false information upon which an insurer relies, if such information was either material to the risk assumed by the insurer or the misinformation was provided fraudulently, may commit a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

In **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.

In **Puerto Rico**: Any person who has committed fraud, as defined in the law, shall incur a felony, and if convicted, shall be sanctioned for each violation by a penalty of a fine of not less than five thousand dollars (\$5,000), nor more than ten thousand dollars (\$10,000), or a penalty of imprisonment for a fixed term of three (3) years, or both penalties. If there were aggravating circumstances, the fixed penalty thus established may be increased up to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years. In addition to the penalties provided in this chapter, any person who, as a result of the fraud thus committed is benefited in any way to obtain insurance, or in the payment of a loss pursuant to an insurance contract, shall be imposed the payment of restitution of the amount of money resulting from the fraud. Every violation shall have a prescription term of (5) five years.

In **Texas**: 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.

In **Vermont**: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.