

AAA Mid States



## Accidental Medical Expense

### HOW TO FILE A CLAIM

1. Complete all items on the attached claim form.
2. Attach the following documents:
  - Copies of fully itemized medical bills. Itemized bills must show the patient's name, date of service, the type of service rendered, the diagnosis or nature of condition being treated and the provider's name and address.
  - Official Police Officer Accident Report
  - Emergency Room Report
3. Send the completed and signed claim form and all required documents to:

ACI Administrative Concepts Inc.  
994 Old Eagle School Road Ste 1005, Wayne, PA 19087  
FAX: 610-293-9299  
Upload Forms: <https://secure.visit-aci.com/insuredlogin.asp>

4. Retain a copy for your records.

**YOU WILL BE CONTACTED BY A CLAIM ADJUSTER IF ADDITIONAL INFORMATION OR DOCUMENTATION IS REQUIRED.**

**IF YOU HAVE ANY CLAIM RELATED QUESTIONS PLEASE  
CALL ACI AT 1-877-444-5011**



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# Accidental Medical Expense Insured's Statement

(Please print – Attach separate sheet if additional space required)

### INSURED INFORMATION

Insured's Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insured's Address \_\_\_\_\_ Phone No. (H) \_\_\_\_\_

\_\_\_\_\_ Phone No. (W) \_\_\_\_\_

Policy Number (Required) 9908-24-75 Insured's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

### CLAIM INFORMATION

Date of accident \_\_\_\_/\_\_\_\_/\_\_\_\_ Time and place accident occurred \_\_\_\_\_

Please describe in detail the circumstances of accident (attach separate sheet if needed): \_\_\_\_\_

Was the accident related to the Insured's occupation? \_\_\_\_\_ If so, how? \_\_\_\_\_

Please describe the nature of Insured's injuries: \_\_\_\_\_

Did police or other authorities investigate the accident? \_\_\_\_ If yes, please provide name, address and telephone number of all investigating officers and agencies: \_\_\_\_\_

Please list the names and addresses of all treating/consulting physicians or other healthcare providers:

<u>Name</u>	<u>Street Address</u>	<u>City</u>	<u>State</u>	<u>Zip</u>	<u>Phone</u>
_____	_____	_____	_____	_____	_____

If hospitalized, please provide name and address of hospital(s) where treatment was received: \_\_\_\_\_

Do you have any other insurance that may provide coverage for this accident or loss? \_\_\_\_ If yes, please identify name, address, and policy number of all other insurance: \_\_\_\_\_

If you do not have any other insurance that would cover this loss please complete the "Certification of No Other Insurance" portion of this form and have it notarized.

### AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize any insurance company, physician, hospital or other healthcare provider, or any other person who may have knowledge regarding this claim to release any information requested regarding this claim and the loss reported. I understand this information will be used by the Chubb Group of Insurance Companies, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim. I understand that 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.

Signed (Insured or authorized person) \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

I authorize payment of medical benefits directly to the provider(s) for services rendered in connection with this claim.

Signed (Insured or authorized person) \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### CERTIFICATION OF NO OTHER INSURANCE

I, \_\_\_\_\_ hereby certify that I have no other accident or health insurance or any other insurance covering this loss.

Signed (Insured or authorized person) \_\_\_\_\_ Dated \_\_\_\_/\_\_\_\_/\_\_\_\_

Sworn and subscribed before me on this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_.

\_\_\_\_\_(Seal)  
Notary Public

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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 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.

**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:** 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.

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## IMPORTANT NOTICE

**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:** 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.

**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:** Any person who, knowingly and with intent to defraud an insurance company or other person, submits an application or files a claim for insurance that contains any materially false information relating to an insurance company's acceptance of risk, or conceals for the purpose of misleading, information concerning any fact material to an insurance company's acceptance of risk, may be guilty of a fraudulent act, which is a crime.

**Notice to Pennsylvania Claimants:** 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.

**Notice to Rhode Island 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 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.