2015 ACE INSURANCE CLAIM FORM

Please Check One:
❑ Plan A ❑ Plan B

IENA
NORTH AMERICAN PROGRAMS

POLICY # GLMN0498335A

DATE OF INCIDENT	Participant ID Code	FLIGHT DATES	
This box must be completed	This box must be completed	Outward	Homeward

COMPLETE APPLICABLE SECTIONS BELOW AND ATTACH SEPARATE COVERING LETTER GIVING FULL DETAILS OF THE INCIDENT AND A COMPLETED HCFA 1500 FORM. YOU CAN OBTAIN THIS FORM FROM YOUR TREATING PHYSICIAN.

I. GENERAL INFORMATION AND INSTRUCTIONS

Your Name _____
(Last) (First) (Middle)

M ❑ F ❑

Date of Birth (MM-DD-YY) _____ Email: _____

Permanent Home address:

_____
_____
_____

Address while in North America:

_____
_____
_____

Name and address of treating Physician(s) *(if applicable):*

_____
_____
_____

ENCLOSE ALL BILLS YOU HAVE PERTAINING TO THE CLAIM
If a claim incurs more than one bill, it is best to submit all bills at the same time. However, if there is a delay in your receiving a bill or a medical claim involves extended or repeated treatment, send a completed copy of this form or a letter to us as soon as possible, and send the bills along as you receive them. If so, please indicate that additional bills are to follow, giving details if possible.
In any case, we should be notified of a pending claim no later than 30 days after the date of the incident.
THIS INSURANCE DOES NOT COVER ANY INCIDENT FIRST OCCURING OUTSIDE THE DATE PERIOD SPECIFIED BY YOU AND AGREED TO BY IENA AND FOR WHICH PREMIUMS HAVE BEEN PAID IN FULL.

II. MEDICAL/DENTAL EXPENSE

(a) Complete the General Information Section I and Section VI.
(b) **All bills must be itemized, include patient's name, diagnosis, dates and description of service.**
(c) Is this claim for **illness** ❑ **accident** ❑ **dental expense** ❑ ?
(d) Nature of illness or injury _____
(e) If illness, have you had it before? **Yes** ❑ **No** ❑
If **Yes**, give date of last treatment _____
(f) If accident, state brief details below (how, when and where the accident happened). Provide a full description in your covering letter, including what you were actually doing at the time of the accident. _____
_____
_____
(g) Did this injury occur while you were at work? **Yes** ❑ **No** ❑
If **Yes,**
(a) Did this injury occur during your scheduled employment hours? **Yes** ❑ **No** ❑
(b) Did this injury occur while you were engaged in your actual employment responsibilities? **Yes** ❑ **No** ❑
If you have answered YES to any part of this question, you may be entitled to benefits under Workers' Compensation insurance and MUST file an incident report with your employer as soon as possible. Please give a full description of the incident in your covering letter. Also please include the date and to whom you made this report, as well as the actual duties you were performing.
(h) Was a motor vehicle involved in this incident? **Yes** ❑ **No** ❑
If **Yes**, give details including vehicle insurance company, policy number, vehicle owner, vehicle driver, etc. in your covering letter.
(i) Payment will be made to the Doctor, Hospital or other Medical Provider. If the bills have already been paid, enclose proof of payment and state in your covering letter the name and address of person(s) to whom reimbursement should be made.

PLEASE WRITE IN BLOCK LETTERS

III. AIR REFUND

(a) Complete the General Information Section I and Section VI.
(b) Payment should be made to _____
_____
(c) Provide certification by legally qualified physician or surgeon as to reason for cancellation.
(d) If death in the immediate family, provide copy of death certificate or certification by legally qualified physician or surgeon, and provide sufficient documentation of your relationship with the deceased (copies of birth or marriage certificates, etc.).
(e) Provide proof of your original "covered flight" and any refund made by your airline/agent. If the ticket was non-refundable, please enclose the original ticket/e-ticket and any proof of non-refundability or refund denial.
(f) Provide proof of actual extra flight costs (e.g. ticket coupons or flight transfer fee receipts).

IV. BAGGAGE INSURANCE

(a) Complete the General Information Section I and Section VI.
(b) In your covering letter, give full details of the incident resulting in the loss or damage.
(c) **Your claim will not be processed unless you include an official verifiable record of loss from police/hotel/airline, etc., dated within 24 hours of date of loss. If a police report is required and not available, please include the crime reference number together with the telephone number and complete address of the police station. If loss is from a rental car, submit copy of rental agreement.**
(d) If loss is in conjunction with travel by airline/bus/train (or other common carrier), coverage may exist under their own insurance policy. If this is not the case, please include their letter of denial.
(e) Attach original receipts and a separate typed or printed list of property lost or damaged specifying purchase date, model number and purchase price. **If receipts are not available, you must provide estimated dates of purchase and original purchase prices. Higher depreciation applies if receipts are not provided.** **Sample:**

Manufacturer (if known)/Item	Purchase Date	Purchase Price
Canon Camera/Model #45689	2 Sept. 2010	£96
Sony MP3 Player/Model #35H	Approx. June 2012	£50 approx.
Oakley Sunglasses	Approx. Apr. 2011	£75 approx.

(f) If property was repaired, include bills. If an item is damaged beyond repair, include a statement to this effect from an appropriate repair service.

V. BAGGAGE DELAY

(a) Complete the General Information Section I and Section VI.
(b) In your covering letter, give full details of incident resulting in the delay or misdirection of your baggage.
(c) Provide written proof from the airline, bus company or other carrier of the delay or misdirection of you baggage.
(d) Attach original receipts and a separate typed or printed list of necessary personal effects which were purchased as a direct result of the delay or misdirection specifying date and price of purchase. **Reimbursement will only be made (up to the policy limits) on items for which original receipts are provided.** **Sample:**

Item	Purchase Date	Purchase Price
Cotton Shirt	2 June 2014	$25
Toiletries	2 June 2014	$20
Trousers	2 June 2014	$35

(e) Provide a copy of your travel ticket on the affected journey.

VI. DECLARATION BY INSURED *Please read carefully before signing.*

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 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 form the date of authorization.

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

I certify that I have read and understand the various state laws printed below.

I agree that to the total extent the Insurance Company pays for losses incurred, it may assume my rights and remedies relating to such loss. I further agree to assist the Insurance Company in preserving its rights against those responsible for such loss, including but not limited to signing subrogation form supplied by the Insurance Company.

Signature:_____ **Date:**_____

PLEASE REMEMBER TO ATTACH YOUR COVERING LETTER AND COMPLETED HCFA 1500 FORM

All claims are to be mailed or emailed by you to: **Administrative Concepts, Inc**
994 Old Eagle School Road, Suite 1005
Wayne, PA 19087-1802
Telephone Queries: **Toll Free: 1-888-293-9229 Phone: 1-610-293-9229 Fax: 1-610-293-9299 8:00am–8:00pm Monday–Friday**
intlassist@visit-aci.com

IT IS THE RESPONSIBILITY OF EACH PARTICIPANT TO FILE HIS OR HER OWN INSURANCE CLAIM FORM, AND TO ENSURE THAT ALL RELEVANT BILLS ARE SUBMITTED TO THE COMPANY AT THE ABOVE ADDRESS. CLAIMS CANNOT BE FILED ON BEHALF OF PARTICIPANTS BY IENA, CAMPS OR EMPLOYERS.

Underwritten by: ACE American Insurance Company of Philadelphia, PA

PLEASE WRITE IN BLOCK LETTERS

The laws of some states require us to furnish you with the following notices:

WARNING. Any person who knowingly:

Alaska: 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.

Arizona and Arkansas: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or **specific to AR:** presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California , Louisiana, New Mexico and Texas : presents a false or fraudulent claim for the payment of a loss or benefit (or **specific to LA and TX:** who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (or **specific to NM:** to civil fines and criminal penalties.)

Delaware: and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Florida: and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky, New York and Pennsylvania: and with intent to defraud any insurance company or other person files an application for insurance, or 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, **specific to PA:** subjects such person to criminal and civil penalties and **specific to NY:** 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.

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

Ohio: 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.

Oklahoma: 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.

WARNING:

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.

District of Columbia, Tennessee and Virginia : It Is a crime to knowingly provide false, incomplete or misleading information to an insurer or insurance company for the purpose of defrauding the insurer or insurance company, (or **specific to DC:** 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.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maine: 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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: 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.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION NEEDED TO ASSIST IN THE DETERMINATION OF THE STATUS OF A CLAIM FILED AGAINST THE MEDICAL INSURANCE POLICY

I hereby authorize International Exchange of North America (IENA) to obtain and *disclose* **Protected Health Information** and disclose such information to the individual(s) indicated below, for the *express* and *limited* purpose to assist in the processing of my claim.

Information to be Used or Disclosed May Include:

[ ] Provider name, address & specialty (required)
[ ] Dates of service (required)
[ ] Cost of services (required)
[ ] Medical diagnosis (optional)
[ ] Services rendered (optional)
[ ] Medications (optional)

Persons or Class of Persons to Whom the Disclosure May be Made:

[ ] Student Health Service Staff
[ ] Employer
[ ] A Specific Individual, as follows:_____
[ ] Student Affairs Staff
[ ] Association Representative

I understand that individually identifiable health information relating to me, which is called *Protected Health Information* as defined by the *Privacy Rule* of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA);* and, that if the person or entity that receives this information is not a health plan, health care clearinghouse, or health care provider as defined in the regulation text of the *Privacy Rule*, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law; and, that I may revoke the authorization at any time by notifying IENA *in writing*. However, if I choose to do so, my revocation will not affect any actions taken by IENA *prior* to my revocation; and, that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits. This authorization expires 60 days after signing, or the date IENA responds to my request for claims status, whichever is earlier.

Insured Member's Name: _____
(print)

Date of Birth: ____/____/____

Claimant is: [ ] Self [ ] Dependent (print full name and indicate relationship to insured)

_____

Patient's or Authorized Representative's Signature:_____

Date: ____/____/____

If Authorized Representative, Relationship to Patient:_____