



Administrative Concepts, Inc.

P.O. Box 4000

Collegeville, PA 19426-9000

Phone: 800-567-3512 Fax: 610-293-9299

Web: www.visit-aci.com

STARR

INSURANCE COMPANIES

Accidental Death Claim Form

SECTION A - CONTACT INFORMATION

Name of decedent/insured _____ Date of birth _____
FIRST LAST

Name of person making this claim _____ Social Security Number _____
FIRST LAST (of decedent/injured)
 (See Page 6 for additional information concerning this request)

Relationship to Insured _____
 Preferred email: _____

Home Telephone _____ Work Telephone _____

Home Address _____ City _____

State/Jurisdiction _____ Postal/ Zip Code _____

Mailing Address _____ City _____

State/Jurisdiction _____ Postal/ Zip Code _____

Preferred Method of Contact: Mail Email Home Phone Work Phone

SECTION B - PLAN INFORMATION

Confirmation/ Policy ID # _____

Booking # _____

Date of departure _____ Date of Return _____
MM / DD / YYYY MM / DD / YYYY

Original Destination _____

Travel Agency Name _____

Initial Deposit Date _____

Agent's Name _____

Agent's Phone Number _____

Agent's Email _____

SECTION C - TRAVELING COMPANIONS

Companion Name _____ Companion Name _____
FIRST LAST FIRST LAST

Policy Number _____ Policy Number _____

Accidental Death Claim Form

SECTION D - ADDITIONAL REQUIRED INFORMATION

When did accident happen? _____ Time _____
MM / DD / YYYY

Where did accident happen? _____
IF CITY OR TOWN, SHOW STREET NUMBER. IF CRUISE, LIST CARRIER.

What was cause of death? _____

Date of Death _____ When did symptoms of cause of death first appear? _____
MM/DD/YYYY MM/DD/YYYY

How did accident happen? _____
DESCRIBE FULLY

List all physicians and surgeons who attended deceased for the injuries causing death.

Name & Address _____
Name & Address _____
Name & Address _____

List all physicians and surgeons who attended deceased during the last five years (state ailments involved).

Name & Address _____
Ailment _____
Name & Address _____
Ailment _____
Name & Address _____
Ailment _____

List all witnesses to accident.

Name & Address _____
Name & Address _____
Name & Address _____

List other coverage's and amounts of insurance in force of deceased's life.

Name of Company	_____	Policy Number	_____
Effective Date	_____	Amount of Insurance	_____
Name of Company	_____	Policy Number	_____
Effective Date	_____	Amount of Insurance	_____

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SECTION E - DOCUMENTATION REQUIRED^{*(b)}

- a) Completed claim forms (signed and dated);
- b) Certified copy of death certificate (required for all claims);
- c) Copies of all police reports, newspaper articles, etc. describing accident;
- d) A completed Medical Authorization for each treating medical facility;
- e) Medical notes (if applicable).

^(b) We reserve the right to request additional information/ documentation as needed to process the claim.

SECTION F - AUTHORIZATION

FAILURE TO SIGN AND DATE MAY DELAY THE REVIEW OF YOUR CLAIM.

FRAUD WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, who files a statement of claim containing any false information, or conceals for the purpose of misleading, Information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to criminal prosecution, civil penalties and forfeiture of insurance benefits.

AUTHORIZATION

I AUTHORIZE any insurance company, physician, hospital, and other health care providers, any travel organization or agency, airline carrier, rental agency, hotel, motel, or similar entity providing lodging on a rental/lease basis or any other person who may have knowledge regarding this claim, to release any information requested to Administrative Concepts, Inc and/or their affiliate partners regarding this claim and the loss reported.

By signing this claim form, I certify that all information given above is true and complete to the best of my knowledge.

Signature: _____ Date Signed: ____/____/____

Print Name: _____

You can create a profile and track this and your other Starr claims using the following link:
<https://www.acitpa.com>

Or, mail the completed and signed claim form and all required documents to:

Administrative Concepts, Inc
P.O. Box 4000
Collegeville, PA 19426-9000

If you choose to mail your documents, please send a copy of your documents and retain the originals for your records. Administrative Concepts, Inc is unable to return any submitted documents. You will be contacted by a claim adjuster if additional information or documentation is required.

Fax: 610-293-9299

Accidental Death Claim Form

Fraud Statements

General: 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.

Alaska: 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.

Arizona: 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.

Arkansas, Louisiana, Maryland, 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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: 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.

Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Delaware, Idaho, Indiana: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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.

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.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: 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. 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.

Michigan, North Dakota, South Dakota: 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.

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

Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

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 section 638:20.

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

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.

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. 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.

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.

Oregon: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law. 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.

Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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.

HIPAA Compliant Authorization To Release Confidential Medical Information

Records and information obtained will be disclosed to the third party administrator, Administrative Concepts, Inc, P.O. Box 4000, Collegeville, PA 19426-9000

The purpose of this disclosure is to evaluate my application for insurance or claim benefits. I hereby authorize for you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all medical and non-medical records and information regarding me are to be released, including, but not limited to, financial, employment, police, complete driving and motor vehicle related records, as well as those relating to past and present illnesses, diagnosis, testing, treatments, and prognosis related to my physical and mental conditions. Such records and information to be released may include, but not be limited to, the following: alcohol abuse treatment and counseling, drug abuse treatment and counseling, psychiatric treatment, pharmacy prescriptions, Acquired Immune Deficiency Syndrome (AIDS), HIV testing and treatment, STD testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKG's.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, ("My Providers"), employers, financial custodians, law enforcement agencies, governmental agencies, medical examiners/ coroners, insurance companies, MIB, Inc. or anyone else located at:

Facility Name: _____ Telephone # _____

Address: _____ City _____ State _____ Zip _____

To release any and all records and information regarding:

Patient's Name: _____
First Middle Last

Other Names Used: _____

Date of Birth (MM/DD/YYYY): _____ Social Security Number: _____ - _____ - _____

Specifics to be released: _____

I understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may become subject to further disclosure by the insurance company. For example, the insurance company may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this Authorization. This Authorization will remain in effect a maximum of six (6) months from my date of signature below. I understand I may revoke this Authorization at any time by requesting such of Administrative Concepts, Inc in writing at its address stated above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this authorization to release my complete medical records, my insurance company may not be able to process my application for coverage, or if coverage has been issued, may not be able to process any benefit payments. I further understand that My Providers cannot condition treatment, payment, or eligibility for benefits on whether I sign this Authorization.

Signature of patient/guardian/personal representative: _____ **Date:** _____

Legal relationship to applicant: _____
(Only if signed above by guardian or personal representative)

Witness signature: _____ **Witness Required**
(Only if required) (only if marked)

Notary signature: _____ **Notary Required**
(Only if required) (only if marked)



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IMPORTANT NOTICE CONCERNING THE COLLECTION OF YOUR PERSONALLY IDENTIFIABLE INFORMATION

Administrative Concepts, Inc is a third party administrator assigned to act on behalf of Starr Indemnity & Liability Company, to process your claim.

Please be advised that your claim cannot be finalized without the ill/injured person's Social Security Number and Date of Birth as the claims administrator for Starr Indemnity & Liability Company will be unable to meet the mandatory reporting requirement outlined below.

The Center for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program.

Section 111 of the Medicare , Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law, was amended and effective July 1, 2009, requires that liability insurers (including self-insurers), no fault insurers , and workers compensation plans report specific information about U.S. citizens, permanent residents, temporary working residents and other social security enrolled individuals who have other insurance coverage.

Information must be reported before payments are made for certain treatment or when certain claimants receive a settlement, judgment or award as a result of a claim. The purpose of requiring reporting of such information is to prevent CMS from paying for medical treatment that another party may potentially be responsible for paying. In addition, this reporting allows CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

As a social security enrolled individual, specific information must be obtained and reported to Centers for Medicare and Medicaid Services before we can process your claim payment. Please note that this information is required of all social security enrolled individuals, even those who are not current Medicare beneficiaries.

Please do not email this information as email is not a secure method of transmission for personally identifiable information.

For fastest service, please upload the required document to our secure website:

<https://www.visit-aci.com>

Or you may mail the required document to:

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