

# COMBINED LIFE INSURANCE COMPANY OF NEW YORK

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

**BOTH SIDES OF CLAIM FORM  
MUST BE COMPLETED AND  
RETURNED WITHIN 30 DAYS.  
COPIES OF ITEMIZED BILLS  
MUST BE ATTACHED**

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. For residents of the following states, please see the reverse side: California, Colorado, District of Columbia, Florida, Maine, Maryland, Nevada, New Hampshire, New York, Oregon, Pennsylvania, Tennessee, Texas or Virginia.

GRADUATE  
 UNDERGRADUATE

- PLEASE PRINT ALL INFORMATION -

**PARTS I & II - MUST BE COMPLETED AND SIGNED BY STUDENT**

Name of College or University, City and State \_\_\_\_\_ Domestic  Policy Number \_\_\_\_\_ Birth Date \_\_\_\_\_  
International

Insured Student's Name \_\_\_\_\_  
LAST NAME FIRST NAME M.I. STUDENT ID # PHONE #

Present Address \_\_\_\_\_  
NO. AND STREET CITY OR TOWN STATE ZIP # + 4

Home Address \_\_\_\_\_  
NO. AND STREET CITY OR TOWN STATE ZIP # + 4

If claim for dependent, give dependent's name \_\_\_\_\_, relationship to Insured \_\_\_\_\_ Age \_\_\_\_\_

**COMPLETE THIS SECTION FOR ACCIDENT CLAIM**

Exact nature of injury \_\_\_\_\_

Date and hour of occurrence \_\_\_\_\_

Was the injury due to practice or play of a sport?  Yes  No

Which sport? \_\_\_\_\_

Intercollegiate  Intramural  Club  Other

Is condition work related?  Yes  No

Is condition due to auto accident  Yes  No

If yes, please attach detailed policy information on all motor vehicles involved in accident.

Were you treated in the Health Service for this condition?  Yes  No

Seen by: \_\_\_\_\_ Date: \_\_\_\_\_

If your claim is for services outside of the Health Service, were you referred?  Yes  No

If not, why? Away from school   
For what reason: \_\_\_\_\_

**COMPLETE THIS SECTION FOR SICKNESS CLAIM**

Date of sickness \_\_\_\_\_

Date symptoms first noticed \_\_\_\_\_

If pregnancy, date of last menstrual period \_\_\_\_\_

What is the exact nature of the sickness? \_\_\_\_\_

Have you ever had the same or similar condition?  Yes  No

If yes, date of first treatment \_\_\_\_\_

Date of last treatment \_\_\_\_\_

Were you treated in the Health Service for this condition?  Yes  No

Seen by: \_\_\_\_\_ Date: \_\_\_\_\_

If your claim is for services outside of the Health Service, were you referred?  Yes  No

If not, why? Away from school   
For what reason: \_\_\_\_\_

**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. 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 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

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 may not be applicable to you if you are not 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, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act.

**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.

**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:** 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.