Mail to: ACE American Insurance Company
1 Beaver Valley Road
P.O. Box 15417
Wilmington, DE 19850

Name of Group:

Policy Number:

ACCIDENT AND SICKNESS CLAIM FORM

Instructions:

1). You must have SECTION A fully completed by a designated official of the Policyholder.
2). SECTION B is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
3). Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service. **PLEASE MAIL COMPLETED FORM AND BILLS TO ABOVE ADDRESS.**

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A – MUST BE COMPLETED AND SIGNED BY A DESIGNATED REPRESENTATIVE OF THE POLICYHOLDER

NAME and/or LOCATION OF GROUP/CLUB/SPORT/SCHOOL. ETC.

CLAIMANT'S FULL NAME (Please Print Clearly or Type)	SOCIAL SECURITY NO. (If Available)	DATE OF BIRTH	NAME OF SUPERVISOR

DATE COVERAGE BEGAN	DATE COVERAGE WILL END/HAS ENDED

NATURE OF INJURY OR ILLNESS. (Describe Fully, Including Which Part Of Body Was Injured.)	DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED (Date And Time.)

NAME OF ACTIVITY	DID ACCIDENT OCCUR:		
	A. WHILE CLAIMANT WAS SUPERVISED	☐ YES	☐ NO
	B. DURING SPONSORED ACTIVITY	☐ YES	☐ NO
INDICATE THE SPORT (If Applicable)	C. DURING PROGRAMMED HOURS	☐ YES	☐ NO
	D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP	☐ YES	☐ NO

DATE LAST WORKED	DATE RETURNED TO WORK	WEEKLY EARNINGS

POLICYHOLDER REPRESENTATIVE (Please Print Or Type)	TITLE	DAYTIME TELEPHONE NUMBER ( )

SIGNATURE OF POLICYHOLDER REPRESENTATIVE	DATE

SECTION B – MUST BE COMPLETED

LIST NAME, ADDRESS, AND PHONE # OF OTHER INSURANCE COMPANIES UNDER WHICH CLAIMANT IS INSURED	POLICY #/ACCOUNT #

IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN/RELATIONSHIP TO CLAIMANT

ADDRESS OF CLAMANT(If Claimant Is A Minor, Name And Address Of Claimant's Guardian)	GUARDIAN'S SOCIAL SECURITY NUMBER

NAME/ADDRESS/TELEPONE # OF EMPLOYER (If Claimant Is A Minor, Guardian's Employer)	EMPLOYER'S DAYTIME TELEPHONE # ( )

BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I *agree* that a photographic copy of this Authorization shall be a valid as the original.
I understand that I or my authorized representative may request a copy of this authorization.
I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative	Dated

Address:

Fraud 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."