When filing a claim with the international carrier, please follow these instructions:

The member completes the attached claim form and submits to ACI for handling. Claims can be submitted in the manner most complimentary to the individual. See below for reporting options:

- EMAIL: aciclaims@visit-aci.com Email attachments cannot be larger than 10 MB.
- FAX: 610-293-9299
- Phone (888)293-9229
- MAIL
  Administrative Concepts, Inc.
  Attn: Claims
  994 Old Eagle School Rd, Ste 1005

Please fill out the form in its entirety, making sure to include the following information so as to ensure no delays in the process:

1. Submit your medical bills that include the date of service, the billed amount, the type of service, and diagnosis. Under the section marked *Other Insurance Coverage*, it would be best to write out ***I do not have other insurance***.
2. Provide proof of your payment for medical treatment received (a credit card statement or if you paid cash a receipt from the medical provider showing you paid the charges).
3. In most cases, a passport copy including entry/exit/visa stamps is required.
4. If you are seeking reimbursement for payments already made, complete the Payment Authorization Section (page 4 of the attached).
5. Make sure to complete all sections legibly and completely. If a question does not apply to you, use N/A.
6. Send the signed form and any accompanying documents to Administrative Concepts Inc. (ACI) within 90 days from the date of service using any of the following methods indicated above.

Please allow 10-15 business days for processing. Once a claim is finalized, payment and/or explanation of benefit statement will be mailed to the insured.

Medical Expense Claim Form– You received medical treatment while on a covered trip.

1. If you have no other insurance, submit your medical bills that include the date of service, the billed amount, the type of service, and diagnosis.
2. If you have other insurance, we need the final statement from your other insurance company listing payment or denial of your claim with them (Explanation of Benefits or "EOB").
3. Provide proof of your payment for medical treatment received (a credit card statement or if you paid cash a receipt from the medical provider showing you paid the charges).
4. In most cases, a passport copy including entry/exit/visa stamps is required.
5. If you are seeking reimbursement for payments already made, please complete the Payment Authorization Form on page 3.
6. Please complete all sections legibly and completely. If a question does not apply to you, please use N/A.

Not sending all the documents will delay the process of your claim.

Send this signed form and any accompanying documents to Administrative Concepts within 90 days from the date of service using any of the following methods:

MAIL	FAX	EMAIL
Administrative Concepts, Inc. **Attn: Claims** 994 Old Eagle School Rd, Ste 1005 Wayne, PA 19087-1802 USA (Allow mail 7-10 days for delivery.)	610-293-9299	aciclaims@visit-aci.com Email attachments can not be larger than 10 MB.

Call for help: (888)293-9229

The furnishing of this form, or its receipt 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. Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

Claim Details

1 Please select the option that best describes your participation in the covered trip

☐ Full-time employee Faculty member on a sabbatical trip Student/Participant of a Sponsored International Educational Program

2 Reason for claim *(You may check both.)* Trip Cancellation Trip Interruption

Coverage Information: This information can be found on your Insurance I.D. Card

3 Insurance company	**4** Name of group/plan	**5** Policy/Certificate Number
Starr Indemnity & Liability Company	**EIIA**	
6 Coverage effective date MM/DD/YYYY	**7** Coverage Termination Date MM/DD/YYYY	

Institution in EIIA Program

8 Name of Institution (College, University, etc.)	**9** Trip Start Date MM/DD/YYYY

Claimant/Patient Information

10 Name of claimant	**11** Date of birth MM/DD/YYYY	**12** Gender: Male Female

Current Address

13 Current Street Address		
14 City	**15** State/Province/Region	**16** Postal Code
17 Daytime phone	**18** Email address	
19 If applicable, date of arrival in U.S. MM/DD/YYYY		

Permanent Address

20 Current Street Address		
21 City	**22** State/Province/Region	**23** Postal Code
24 If applicable, date scheduled to return to home country. MM/DD/YYYY		

Medical Information

25 If Injured, provide details, such as how, when, and where injury occurred.		
26 Name of Claimant/Patient	**27** Policy/Certificate number	
28 If illness, advise when and where symptoms first occurred and nature of illness.		
29 Name of consulting or treating physicians		
30 Street address of physician		
31 City	**32** State/Province/Region	**33** Postal Code
34a Have you ever been treated for this Illness before? Yes No	**34b** If YES, when were you treated? MM/DD/YYYY	
35 Name of your primary care physician in your home country.		
36 Street address of your primary care physician in your home country.		
37 City	**38** State/Province/Region	**39** Postal Code

Other Insurance Coverage

40 Name other employer/private/government medical insurance coverage	**41** Policy/certificate number	
42 Street address		
43 City	**44** State/Province/Region	**45** Postal Code

Prescriptions

46 List prescription medications you are taking or took during the past 6 months *not* related to your injury or illness.	**47** List prescription medications prescribed for your injury or illness.

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, relative or benefit plan administrator to furnish to Administrative Concepts, Inc. any and all information with respect to any injury or illness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, illness or loss is the basis of the claim and copies of all 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 identified above. I authorize the group policyholder, employer or benefit plan administrators to provide Administrative Concepts, Inc. with financial and employment related information and documents. I agree that I will provide Administrative Concepts, Inc. with any medical records, or other records, requested by Administrative Concepts, Inc. to process the claim. I understand that my failure to provide requested documents to Administrative Concepts, Inc. may result in denial of the claim. I understand that failure by any of the above referenced entities or individuals to provide information or documents to Administrative Concepts, Inc. may result in denial of the claim. In addition, I hereby certify that the above information is true and correct to the best of my knowledge and belief. I understand that any false statements made on this form or omissions of information requested by this form may result in denial of the claim. I acknowledge and understand the Fraud Notices on Page 4 of this document. 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.

48 Signature of Patient/Claimant or Parent, If Claimant is a Minor	**49** Date MM/DD/YYYY

Payment Authorization Form

- To prevent any delays in claims handling, please be sure to sign this form.
- The ***Name*** in contact information must match exactly the name on the ACH, checking, or wire transfer account.
- Joint accounts require all names.

Contact Information

Name *Account Holder(s)*	Telephone		
Email address	I authorize Administrative Concepts, Inc. to contact me using this email address to discuss and/or inform me of payment confirmation. **yes** **no**		
Mailing address (P.O. boxes are not accepted)	City	State/Province/Region	ZIP/Postcode

1 Payment Type

☐ Check (check will ship to address above) ACH/EFT: US $ Canada(CAD) $ – complete section 2

☐ International Wire Transfer – complete section 3

2 U.S. Account Information

Account type: Checking Savings	Full Bank Name:		
Bank street address	City	State	Zip Code/ Postcode
ABA routing number	Account number	SWIFT BIC	

3 International/non-U.S. Account Information - Complete for payment through bank transfer outside the U.S.

Bank's full name			
Bank street address	City	State/Province/Region	Zip Code/ Postcode
Account number	Routing Number (BLZ, BSB, TRNO, branch code, etc.)		
IBAN	SWIFT BIC	Preferred reimbursement currency	
REGULATORY INFORMATION			
Bank phone number	Identification number		
	Account type: ID NIT RIF CPF CNPJ RUT CUIT OTHER		

I hereby authorize Administrative Concepts, Inc. (hereinafter COMPANY) to mail any payments to the above listed address and to deposit any amounts owed me for reimbursement of medical expenses or services rendered by initiating credit entries to my account at the financial institution (hereby BANK) indicated above. Further, I authorize BANK to accept and to credit any credit entries indicated by COMPANY to my account. In the event that COMPANY erroneously deposits funds in my account (by way of example, I am not entitled to the funds or the amount of deposit Is incorrect or such funds are deposited in the wrong account), I authorize COMPANY to debit or credit my account in the amount necessary to correct the initial deposit, but in no case shall any debit exceed the amount of the initial deposit. I further agree COMPANY is not responsible for any transaction fees charged and will release Administrative Concepts of any liability in the event of lost or stolen payments.

Account holder signature	Date

Claim Form Fraud Statement - For residents of all states other than those listed below:

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.

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.

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.

CALIFORNIA: 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 fins 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.

FLORIDA WARNING :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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

KANSAS: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

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

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

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 and 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.

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: 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.

TENNESSEE: 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.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: 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 may have violated state law.

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