MAIL TO:
Administrative Concepts, Inc.
994 Old Eagle School Road
Suite 1005
Wayne, PA 19087-1802
www.visit-aci.com

Arch Insurance Company

Dismemberment Claim Form

(No Liability is admitted by the issue of this form)

COMPLETE IN DETAIL TO ENSURE PROMPT HANDLING

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

IMPORTANT: This form must be completed in full by claimant and the attending physician. There must have been confinement in a hospital as an inpatient due to injuries received in a covered accident in order to be eligible for benefit consideration.

Insured Information

Name of Insured: | | |
Last Name | First Name | M.I. | Certificate Number | Policy #

Home Address:
and Street | City/Town | State | Zip Code

Home Telephone ( ) | Business Telephone ( ) | Fax ( )

Occupation: | Date of Birth: | Social Security Number

Complete if Claim is for Dependent

Name of Dependent:
Last Name | First Name | M.I.

Relationship to Insured: | Date of Birth:

Complete for all claims

Date of Accident: | Date first treated by Physician: | Name of Physician:

Physicians Address
and Street | City/Town | State | Zip Code

Describe how accident occurred:

Where did accident occur:

Describe the bodily injuries:

Did the Injury happen at work: Yes ☐ No ☐ Has a claim or will a claim be filed under worker's compensation? Yes ☐ No ☐

1	Name and address of Hospital	Date Admitted	Date Discharged
2	Name and address of Hospital	Date Admitted	Date Discharged

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:

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Dismemberment Claim

Name of Patient: Last Name First Name M.I.	Date Of Birth:
Date Admitted:	Date Discharged:

Complete if Claim is for Dependent

Name of Dependent: Last Name First Name M.I.	Relationship to Insured	Date of Birth

Attending Physician's Statement

Diagnosis and concurrent conditions(if diagnosis code other than ICDA used, provide name):

Is Condition Due to Injury or sickness arising out of patient's employment? Yes ☐ No ☐

Is Condition Due to Injury or sickness arising out of pregnancy? Yes ☐ No ☐

If "yes", approximate date pregnancy commenced:

Report of Services

(To be completed for all coverages. Itemized bill must be attached.)

Date of Services	Place of Services *	Description of surgical or medical services rendered	Procedure code **

*** Place of Services**	DO- Doctors Office	IH- Inpatient Hospital	NH- Nursing Home	**** Procedure Codes**	CPT- Current Procedural Terminology	
	H- Patients Home	OH- Outpatient Hospital	OL- Other Locations		ICDA- International Classification of Diseases	

Date Symptoms first appeared or date of accident:	Date patient first consulted you for this condition:

Has patient ever had same or similar condition? Yes ☐ No ☐
If "yes", when and describe

Is patient still under your care for this condition? Yes ☐ No ☐

Does patient have other insurance coverage? Yes ☐ No ☐
If "yes", please identify

Name of Physician (print): Last Name First Name M.I. Degree	Signature
Street Address: # and Street City/Town State Zip Code Telephone	

As required by law, please provide

Social Security Number _____ or Tax ID Number _____

NOTICE: ANY PERSON WHO, KNOWINGLY OR WITH INTENT TO DEFRAUD OR TO FACILITATE A FRAUD AGAINST ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM FOR INSURANCE CONTAINING FALSE, DECEPTIVE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO ARKANSAS, LOUISIANA AND NEW MEXICO RESIDENTS: 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.

NOTICE TO 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.

NOTICE TO DISTRICT OF COLUMBIA RESIDENTS: 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.

NOTICE TO 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 in the third degree.

NOTICE TO KENTUCKY RESIDENTS: Any person who knowingly and with the intent to defraud any Insurance Company or other person files an application for insurance 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.

NOTICE TO MAINE RESIDENTS: It is a crime to 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.

NOTICE TO NEW JERSEY RESIDENTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO 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 five thousand dollars and the stated value of the claim for each such violation.

NOTICE TO OHIO RESIDENTS: 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.

NOTICE TO OKLAHOMA RESIDENTS: 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.

NOTICE TO PENNSYLVANIA RESIDENTS: Any person who knowingly and with the 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.

NOTICE TO PUERTO RICO RESIDENTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps, or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON 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.