International Student and Scholars Accident and Sickness Insurance Plan

ACE North American Claims

MAIL FORM TO:
Klais & Company, Inc.
Benefit Consultants and Administrators
1867 West Market St.
Akron, OH 44313-6977
Tele: 800-331-1096
E-mail: klaisclaims@klais.com

TO BE COMPLETED BY INSURED PERSON

1. School Name: ____ Policy #__________________
2. Insured Person: ____ Group #__________________
3. Local Address:____
4. Home Address: ____
5. Date of Birth: _____/_____/_____ Local Phone: ( ) ____________________ Home Phone: ( ) ____________________
6. Patient Status: __ Male __ Female ___Single ___ Married Social Security # (if applicable)_______-_______-_______

   Is this claim for a dependent? __ Yes __ No If yes, give name: ______________________

   Relationship: ____________________ Date of Birth: _____/______/______

COMPLETE THIS SECTION FOR ACCIDENT CLAIM

7. Is this claim the result of an accident: ___ Yes ___ No If "yes", give date of accident: _____/_____/_____ Time of Accident: ___________
8. Is this claim the result of a work-related injury? ___ Yes ___ No

   Is this claim the result of an auto accident? ___ Yes ___ No

   Is this claim the result of sports participation? ___ Yes ___ No If "yes" ___intercollegiate ___intramural ___club ___ other
9. Where did the accident occur? ____

   How did the accident happen? ____

COMPLETE THIS SECTION FOR SICKNESS CLAIM

10. Name of physician: ____ Date of initial service _____/_____/_____
11. Description of Illness or Injury: ____
12. Has the patient been treated for the above condition(s) in the last 12 months? __ Yes __ No

    If "yes", give condition(s) treated for and date(s) of treatment: ______________________________

COMPLETE THIS SECTION FOR ALL CLAIMS (ACCIDENT OR SICKNESS)

13. Is patient covered for benefits by any other Group Health, Employer, Union, Welfare Plan or Parent Health Plan? ___ Yes ___ No

    If answered "yes", please complete the following:

    Coverage provided through:

    Name of Person________________________________ Relationship ____________________________

    Address ______________________________________ Address _________________________________

    Telephone ( ) ____________________ Telephone ( ) ____________________ Policy # _______

    Please include a photocopy of other plan identification card, if available.
14. To be completed regardless of age of patient:

    Is patient covered under MEDICARE Hospital Insurance (Part A) __ Yes Eff. Mo. _____/Day_____/Yr._____ __ No

    Is patient covered under MEDICARE Hospital Insurance (Part B) __ Yes Eff. Mo. _____/Day_____/Yr._____ __ No
15. I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacist to release any information requested with respect to this claim.

    It is unlawful to knowingly provide false, incomplete or misleading facts or information regarding a claim for the purpose of defrauding or attempting to defraud to receive benefits. Penalties may include imprisonment, fines, denial of benefits and/or civil damages. 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 fines and confinement in state prison.

Signature of Insured ____ Date ______________ 20___

Signature of Claimant ____ Date ______________ 20___

COMPLETE THIS SECTION ONLY IF YOU WISH THE BENEFITS TO GO DIRECTLY TO THE PROVIDER(S)

Authorization to Pay Benefits: I hereby authorize payment directly to: any physician or provider of service for which I am submitting attached billings and charges.
For the expenses provided under my Group Medical Expense Benefits, I understand I am financially responsible for charges not covered by this authorization.

Signature ____