Insurance Claim Filing Instructions

PROOF OF ACCIDENT AND SICKNESS MEDICAL EXPENSE SHALL CONSIST OF THE FOLLOWING:

1. A completed and signed claim form
2. Official Accident, Incident, Toxicology or Medical Examiners Reports
3. Authorization to obtain medical records
4. Copy of the Ambulance report or medical report, if available
5. Itemized medical bills, which include all UB04 hospital bills, CMS 1500 / HCFA, physician bills

   Important: an itemized medical bill must show:

   a. Claimant's Name
   b. Nature of Injury/Sickness
   c. Date of Service and Description and Charge for each service provided
   d. If no Nature of Injury/Sickness is indicated on the bill, please ALSO provide office notes from the treating doctor or hospital to support this Nature of Injury/Sickness.

A PROPERLY COMPLETED CLAIM FORM WILL ASSIST US IN THE PROMPT PROCESSING OF YOUR CLAIM

Return Claim Form to:

AMA & Associates
ATTN: Claims Department
PO Box 65139
San Antonio, Texas 78265
1-800-456-7480
Fax: 210-822-4113
customerservice@amaofsa.com

Note: If you need additional space in order to complete the Claim Form, please attach a separate sheet of paper with your responses.

Fraud Warning for Claim Forms

WARNING – Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

For AR 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 person.

For CO residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance 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.

For DC residents: Warning: It is a crime to provide false or misleading information to an insurer for the purposes 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.

For FL 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.

For KS residents: A "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

For KY residents: Any person who knowingly and with 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.

For LA 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.

For ME 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 may include imprisonment, fines or a denial of insurance benefits.*"

For MD residents: 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.

For NJ residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For NM 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 CIVIL FINES AND CRIMINAL PENALTIES.

For NY resident: General: All applications for commercial insurance, other than automobile insurance: 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.

The proposed insured affirms that the foregoing information is true and agrees that these applications shall constitute a part of any policy issued whether attached or not and that any willful concealment or misrepresentation of a material fact or circumstances shall be grounds to rescind the insurance policy.

For OH 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.*"

For OK 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.*"

For PA residents: All Commercial Insurance, Except As Provided for Automobile Insurance: 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.

For Puerto Rico residents: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For RI 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.

For TN residents: All Commercial Insurance, Except As Provided for Workers' Compensation 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.

For VA 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.

For WA 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.

For WV 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.

All Other States: Any person who knowingly and willfully presents false information in an application for insurance may be guilty of insurance fraud and subject to fines and confinement in prison. (In Oregon, the aforementioned actions may constitute a fraudulent insurance act which may be a crime and may subject the person to penalties).

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A. INSURED INFORMATION

Are you a United States Citizen? No ☐ Visa Type_____ Yes ☐ Social Security Number _____

Insured's Name_____ Date of Birth:_____ Sex: ☐ Male ☐ Female
Month/Day/Year

Insured's Address _____

Country and city where claim occurred:_____

Phone Number_____ E-mail Address _____

Name of College/University/Group: Academic Programs International, LLC Group No. 2160 Policy No. BAH 4001808 0818

B. CLAIMANT INFORMATION (If different from above)

Claimant's Name_____ Relationship to Insured if a Dependent_____

Claimant's Address_____

Date of Birth_____ Social Security Number (if applicable)_____
Month/Day/Year

ARE YOU ENROLLED IN MEDICARE ☐ Yes ☐ No IF NO, DO YOU PLAN TO ENROLL ☐ Yes ☐ No

C. AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by Catlin Insurance Company, Inc. or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I hereby authorize Catlin Insurance Company, Inc. or its authorized representative to release any information requested herein to any expert, investigator, physician, medical practitioner, hospital, medical or medical related facility, insurance company, reinsurer, plan administrator, plan sponsor or employer for the purpose of investigating and /or adjudicating this claim. A copy of this authorization shall be considered as effective and valid as the original.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Authorized Person)_____ Date _____
Electronic Signature Not Valid Month/Day/Year

Print Name Here _____

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Accident Medical Expense Claim

A. DESCRIPTION OF ACCIDENT:

Name:_____ Date of Birth:_____

Date of Accident_____ Time of Accident_____ Location of Accident _____
Month/Day/Year

Please describe in detail the circumstances of accident and the cause of the covered loss (attach separate sheet if needed)
Was the Injury on the left or right side of the body? ☐ Right Side ☐ Left Side_____

_____

_____

Did the Accident occur during the course of the Claimant's employment? _____
Did the Injury occur during practice or play of sports? ☐ No
☐ Yes - check: ☐ Club ☐ Intercollegiate ☐ Recreational ☐ Other -explain

Name of Sport _____ _____

Intercollegiate injuries require signature of school official: _____
Electronic Signature Not Valid

B. REQUIRED ACCIDENT DOCUMENTATION

The following documents must accompany this Accident claim form: **- Police Report (if applicable)**
- Itemized Medical Bills (See Page 1 for Instructions)

Sickness Medical Expense Claim

A. DESCRIPTION OF SICKNESS:

Name:_____ Date of Birth:_____

Date when Sickness/Symptoms first occurred _____
Month/Day/Year

Type of Sickness. What prompted your need for medical treatment?_____

_____

Is this condition work related? ☐ No ☐ Yes, please explain _____

Have you had this same or similar condition before? ☐ No ☐ Yes If yes, when_____
Month/Day/Year

If previously treated for this condition, provide name and address of physician and hospital_____

_____

Were you taking any medications prior to the effective date of this insurance: ☐ No ☐ Yes If yes, please provide the following

Drug Name_____	Drug Name_____	Drug Name_____
Prescribed for_____	Prescribed for_____	Prescribed for_____
Physician Name_____	Physician Name_____	Physician Name_____
Date First Prescribed_____	Date First Prescribed_____	Date First Prescribed_____

B. REQUIRED SICKNESS DOCUMENTATION

The following document(s) must accompany this Sickness claim form: **- Itemized Medical Bills (See Page 1 for Instructions)**

AUTHORIZATION
FOR RELEASE OF INFORMATION

CLAIMANT (name) _____

POLICY NUMBER: _____ **BIRTH DATE:** _____
Month/Day/Year

Solely to assist Catlin Insurance Company, Inc. in administering an insurance claim, I hereby authorize any physician, doctor, dentist, clinic, hospital, pharmacy, or other medical professional, or any insurance company, employer, coroner, medical examiner, law enforcement agency, governmental agency or other person or organization possessing medical, employment, financial, insurance and/or police record information on the individual named above, to permit Catlin Insurance Company, Inc., its affiliates or its representatives, to view, copy, be furnished copies or be given details of my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This protected health information and other information includes any medical information, employment or financial information, insurance policy and claim history, and/or police record information including but not limited to, mental and physical condition, evaluation, diagnosis, treatment, prognosis, autopsy protocol and findings, and/or toxicology results; specifically to include drug, alcohol, mental illness, psychiatric treatment or diagnosis, testing, and/or treatment of HIV (AIDS virus) and/or other sexually transmitted diseases.

By my signature below, I terminate any agreements I have made with my providers to restrict my medical records and any associated HIPAA protected health information and I instruct my providers to release and disclose my entire medical record without restriction.

This protected health information and other information is to be disclosed under this Authorization so that Catlin Insurance Company, Inc. may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with Catlin Insurance Company, Inc., its subsidiaries and affiliates.

This Authorization is valid from the date signed for the duration of the claim not to exceed 24 months from the date of signature. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Catlin Insurance Company, Inc.. I understand that a revocation is not effective if any of my providers has relied on this Authorization or to the extent that Catlin Insurance Company, Inc. has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I also understand that if I refuse to sign this Authorization, Catlin Insurance Company, Inc. may not be able to process claims or properly administer coverage and may result in a denial of coverage. I understand the company will provide me with an additional copy of this Authorization.

Any copy of this Authorization shall have the same authority as the original.

Authorization given by (sign name here): _____
Electronic Signature Not Valid

Print Name Here: _____

Date Signed: _____

Relationship to Claimant: _____