Reset Form

Accident Claim Form

MAIL TO: AGIA
P.O. Box 9851
Phoenix, AZ 85068

QUESTIONS? CONTACT: 800-399-2560

Beech Street Corporation
The Managed Care Company

Beech Street Preferred Provider Network Plan

CIGNA Group Insurance
Life • Accident • Disability
Life Insurance Company of North America
CIGNA Life Insurance Company of New York

CAUTION: Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. ***Residents of the following states, please see reverse side: CA, CO, DC, FL, NY, TN, TX and VA.***

INSTRUCTIONS

The policy is Full Excess unless otherwise noted in the policy. Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You **must** submit your claim to your other insurance company first. When you receive their Benefits Statement (EOB) send it to us along with the itemized bills.

- **Part I -** Must be completed by Policyholder.
- **Part II -** Must be completed by claimant or by the parent or guardian, if the claimant is a minor.
- Send copies of itemized bills showing provider's name, address, tax ID number, diagnosis and procedure codes.
- Attach Explanation of Benefits, additional bills with record of payment or denial from primary insurance carrier.
- All benefits will be payable to the physicians and providers, unless accompanied by paid receipts.
- If employed, but have no other insurance, forward employer(s) letter on employer(s) letterhead to that effect.

Claimants eligible for Medicaid benefits must first file for benefits under this policy before submitting expenses to Medicaid.

PART I - POLICYHOLDER REPORT

Name of Policyholder		Policy Number	
Policyholder Street Address	City	State	Zip Code
Policyholder Contact	Telephone No. ( )	Fax No. ( )	E-Mail
Name of Claimant *(Last Name)*	*(First Name)*		Social Security No.
Date of Birth / /	Sex ☐ Male ☐ Female	Grade *(if applicable)*	Check One *(if applicable)* ☐ Day School ☐ Boarding School

Nature of Injury *(Describe, fully indicate what part of body was injured - e.g. broken arm, sprained ankle)*

Describe how the Accident occurred, provide all details. Attach a separate sheet, if necessary. **MUST BE A BODILY INJURY DUE TO ACCIDENT.**

Did Accident occur:

While claimant was policyholder supervised? ☐ Yes ☐ No Date of Accident: ____/____/ _____ Time of Accident: _____

During a policyholder sponsored activity? ☐ Yes ☐ No Place of Accident: _____

During scheduled policyholder hours? ☐ Yes ☐ No First Treatment Date: ____/____/ _____

While traveling to or from a policyholder sponsored and supervised activity? ☐ Yes ☐ No

Off Policyholder premises, at home, during the weekend, holiday or summer vacation? ☐ Yes ☐ No

Name and title of person supervising activity? _____ Was he or she a witness? ☐ Yes ☐ No

List other Policyholder insurance. Attach separate sheet, if necessary. Policy Number(s)

Signature of Authorized Policyholder Representative **Title** **Date**

PART II - TO BE COMPLETED BY CLAIMANT OR PARENT / GUARDIAN, IF CLAIMANT IS A MINOR

Name of Father or Guardian	Social Security No.	E-Mail Address
Name of Mother or Guardian	Social Security No.	E-Mail Address

Street Address of Parents or Guardian	City	State	Zip Code	Telephone No. ( )

Father or Guardian's Insurance Company	Mother or Guardian's Insurance Company

Name & Address of Father and Mother's or Guardian's Employer	Address	City	State	Zip Code

PART II - TO BE COMPLETED BY CLAIMANT OR PARENT / GUARDIAN, IF CLAIMANT IS A MINOR *(Continued)*

List all other insurance policies under which claimant is insured — Policy Number

Is the claimant enrolled in, a member of, or a participant of any of the following as an individual, employee or dependent? If so, please provide a copy of insurance card *(front and back).*

Preferred Provider Organization (PPO) or similar prepaid health plan? ☐ Yes ☐ No

If Yes, name of PPO or Organization _____

Health Maintenance Organization (HMO) or similar prepaid health plan? ☐ Yes ☐ No

If Yes, name of HMO or Organization _____

If claimant has health care coverage as a dependent from a previous marriage as mandated in a divorce decree, please provide the following:

Name of Policyholder | Name of Insurance Company | Policy Number

AFFIDAVIT: I verify that the statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the Company to the extent for which the Company would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to any CIGNA company, the Plan Administrator or their employees and authorized agents for the purpose of validation and determining benefits payable. This data may be extracted for the use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of this claim.

PAYMENT AUTHORIZATION: I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

Signature *(Parent or Guardian, if the claimant is a minor)* — **Date**

IMPORTANT CLAIM NOTICE

California & Texas Residents: 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.

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 settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

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.

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 of the third degree.

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 $5,000 and the stated value of the claim for each such violation.

Tennessee 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.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.

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