Administrative Concepts, Inc.
PO Box 4000
Collegeville, Pennsylvania 19426

CLAIM FORM

PLEASE COMPLETE IN FULL TO ENSURE PROPER PROCESSING

SCHOOL/ORGANIZATION 学校名称	POLICY NUMBER (CAN BE FOUND ON ID CARD) Policy#(保险确认信上可见)		勾选性别
INSURED'S LAST NAME 姓氏	INSURED'S FIRST NAME 名字	MI	☐ FEMALE ☐ MALE
INSURED'S U.S. MAILING ADDRESS—NUMBER AND STREET NAME (OR P.O. BOX #), CITY, STATE, ZIP 邮寄地址			
INSURED'S DATE OF BIRTH (MM/DD/YYYY) 出生日期	INSURED'S PHONE NUMBER 电话号码	INSURED'S MEMBER ID NUMBER Member#(见保险卡)	VISA TYPE: 签证类型 ☐ F1 ☐ J1 ☐ OTHER _____
VISA NUMBER 签证号码	PASSPORT NUMBER 护照号码	PASSPORT ISSUING COUNTRY 护照签发国家	NOTE: If you hold a J-1 Visa, please attach a copy of your DS-2020 form from the University.

If claimant is a Dependent currently insured under this plan, complete information below (in addition to the above).
(如果是一同投保的的dependent申请理赔，请填写此部分)

CLAIMANT'S LAST NAME	CLAIMANT'S FIRST NAME	MI
CLAIMANT'S U.S. MAILING ADDRESS —NUMBER AND STREET NAME (OR P.O. BOX #), CITY, STATE, ZIP		
CLAIMANT'S DATE OF BIRTH (MM/DD/YYYY)	☐ FEMALE ☐ MALE	CLAIMANT'S PHONE NUMBER

SECTION 1 – INJURY OR SICKNESS INFORMATION
申请理赔的项目是疾病还是受伤？如果是疫苗，请选择sickness

1. Is this claim pertaining to a sickness/medical condition or an injury? ☐ Sickness 疾病 ☐ Injury 受伤 If injury, please fill out the information below. 如果是受伤，请完成填写下方的部分
   If claim is for a sickness/medical condition, skip to Section 2.

   a) How and where injury occurred; and brief description of injury:
   你是怎么以及是什么时候受伤的？请简短的描述一下受伤情况

   Date of Injury: _____ 受伤的日期

   b) Did injury occur at work? ☐ Yes ☐ No If yes, name of employer: 如果是的话，请把你公司的名称写下来
   你是在工作的时候受伤的吗？

   c) Did injury occur during a motor vehicle accident? ☐ Yes ☐ No
   你是在车祸中受伤的么？

   d) Did injury occur during practice or play of school-sponsored sports? ☐ Yes ☐ No If yes, please complete information about the sport below.
   你是在参与学校运动练习时受伤的么？ 如是，请填写红框内剩余部分
   Name of Sport: _____ ☐ Intercollegiate ☐ Intramural/Club

   If intercollegiate, report to trainer and get signature. Signature of Athletic Trainer: _____

SECTION 2 – REFERRAL INFORMATION 转诊信息。如没有转诊，请选择N/A跳到Section 3

2. Did you visit the campus health center for treatment of this injury or sickness? ☐ Yes ☐ No ☐ N/A (skip to Section 3)
   你是去学校校医务室看病的吗？
   If yes, signature and title of health center official: 如果是的话，请让校医务室的工作人员签字

3. Did you receive a referral to an outside doctor by the campus health center, or from one provider to see different provider? ☐ Yes ☐ No ☐ N/A
   你有从校医务室或是医生那边得到转诊证明吗？
   If yes, please send a copy of the referral with this form. 如有，请附上转诊证明

SECTION 3 – OTHER INSURANCE INFORMATION (CURRENT) 第二份保险的信息

除了这个保险以外，请问你还有第二份保险吗？

4. Do you have *other* insurance which covers your condition such as a group or individual health plan, government health plan, or automotive insurance plan (if auto accident)? ☐ Yes ☐ No 如果有的话，请完成下面的部分

   保险持有者是谁？ 自己 父母 配偶
   If yes, who is the Policyholder? ☐ Self ☐ Parent ☐ Spouse Name of Insurance Carrier: 保险公司名称

   Member No.: （见保险卡上） Group No.: （见保险卡上） Insurance Co. Phone No.: 保险公司电话号码

   Primary Insured's Name (Parent/Spouse/Self): 保险持有者的姓名

Clear Form

SECTION 4 – PRIOR INSURANCE COVERAGE 之前使用的保险（选填）

5. Did you have *prior* insurance which covered your condition, such as a group or individual health plan, government health plan, or automotive insurance plan (if auto accident)? ☐ Yes ☐ No 请问您之前有持有过保险么，包括个人医保，团体医保，政府医保，或者车险?

If yes, who is the Policyholder? ☐ Self ☐ Parent ☐ Spouse Name of Insurance Carrier: 保险公司名称
如果有，保险持有者是谁?

Coverage Effective Date: 保险生效日 Coverage Term Date: 保险截止日

Member No.: Member ID Group No.: Group ID Insurance Co. Phone No.: 保险公司电话

Primary Insured's Name (Parent/Spouse/Self): 投保人姓名

SECTION 5 – ASSIGNMENT OF BENEFITS

6. Indicate below to whom payment is to be made:

☐ 医疗费用还没有被垫付，请直接赔付给医生/诊所/医院
Balance is owed to the provider of service. Please pay the provider as indicated on billing statement.

☐ 医疗费用已经被垫付，理赔支票需要寄给理赔申请者
Expenses have been paid. Please reimburse the student or claimant listed above.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Relation Insurance Services, or their employees and authorized agents for the purpose of validating and determining benefits payable. A photocopy of this authorization shall be as valid as the original. I certify the above information to be true and correct.

Patient's or Authorized Representative's Signature 签名 Date 日期

If student is under age 18, must be signed by a parent, guardian, or sponsor.