Send this claim form, PRIMARY INSURANCE EXPLANATIONS OF BENEFITS, and ITEMIZED BILLS to:

A-G ADMINISTRATORS, INC.
P.O. BOX 979
VALLEY FORGE, PA 19482

QUESTIONS?
Call 800-752-2008 PA
800-634-8628

Fraud Warning: 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. For residents of the following states, please see end of the form: California, Colorado, District of Columbia, Florida, New York, Tennessee, Texas or Virginia.

College or University _____ STUDENT'S SOCIAL SECURITY NUMBER

Student's Name _____ ❑ M ❑ F

Student's School Address _____

Student's Home Address _____

Phone Numbers (School) _____ (Home) _____ Date of Birth _____

If Claim is for a Dependent:

Name _____ Relationship _____ Date of Birth _____

I authorize the release of any medical information necessary to process this claim.

_____ _____
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE **DATE**

A, B OR C MUST BE COMPLETED		
A. IF A SICKNESS	NATURE OF ILLNESS	
	DATE ILLNESS BEGAN	DATE OF FIRST TREATMENT
	NAME AND ADDRESS OF ATTENDING PHYSICIAN	
B. IF AN ACCIDENT	PLACE OF ACCIDENT	DATE & TIME
	NATURE OF INJURY	
	WHAT HAPPENED?	

IS THIS AN AUTOMOBILE ACCIDENT? ❑ YES ❑ NO

C. IF AN INTER-COLLEGIATE SPORTS ACCIDENT	PLACE OF ACCIDENT	DATE & TIME
	NATURE OF INJURY	WHICH SPORT?
	Are you aware of any other insurance program covering this athlete? _____ I certify that the above accident resulted from the supervised practice or play or travel to and from an intercollegiate sport.	
	SIGNATURE OF ATHLETIC DEPARTMENT OFFICIAL	**TITLE** **DATE**

SEE REVERSE SIDE OF FORM. ATTACH ITEMIZED BILLS TO THIS FORM OR HAVE PHYSICIAN COMPLETE PORTION ON REVERSE.

Some of our plans provide benefits on an excess of other coverage basis. Therefore, we appreciate your completing this section. Please give details.

1. Are you covered under a Blue Cross or Blue Shield program? ❑ Yes ❑ No Policy # _____

2. Are you covered under any other health insurance program? ❑ Yes ❑ No Name & Policy # _____

3. Name and address of your father's employer _____

4. Name and address of your mother's employer _____

PHYSICIAN OR SUPPLIER INFORMATION	
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	
DATE OF ACCIDENT OR DATE OF FIRST SYMPTOMS	DATE FIRST CONSULTED YOU FOR THIS CONDITION
NAME & ADDRESS OF REFERRING PHYSICIAN	
PHYSICIAN'S OR SUPPLIER'S NAME AND ADDRESS (Please type or print)	SOCIAL SECURITY NUMBER OR FEDERAL TAX I.D. NUMBER (Cannot process without this number)
SIGNATURE OF PHYSICIAN OR SUPPLIER	**DATE**

AUTHORIZATION

I AUTHORIZE ANY PHYSICIAN AND/OR HOSPITAL TO RELEASE SUCH INFORMATION AS RELATES TO THIS CLAIM TO A-G ADMINISTRATORS, INC.

SIGNATURE _____ DATE_____

FRAUD WARNING

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 a 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 five thousand dollars 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 an application or files a claim containing a false or deceptive statement may have violated state law.