

# ACE AMERICAN INSURANCE COMPANY

## Claim Instructions

\*Attach itemized bills, showing treatments, and dates of treatment and charges to the claim form, forward additional bills to the above address. \*Do not leave claim form at hospital. \*Payment Will be made to the doctor or hospital, etc., unless a paid receipt or statement is attached. \* No additional claim form is necessary.

### MAIL TO:

T.W. LORD & ASSOCIATES  
P.O. BOX 1185  
MARIETTA, GA 30061  
PHONE 1-800-633-2360

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## To Be Completed By Claimant

### STUDY ABROAD

Claimant's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Last Name First Name  
Present Address \_\_\_\_\_  
No. & Street City or Town State Zip  
Social Security # \_\_\_\_\_ Geographic Location of accident/illness \_\_\_\_\_

\_\_\_\_\_ Date of accident or sickness

\_\_\_\_\_ Nature of sickness or injury

\_\_\_\_\_ If injury, describe fully how and where accident occurred

\_\_\_\_\_ Have you ever had the same or similar symptoms \_\_\_\_\_ Yes \_\_\_\_\_ No If so, when?

\_\_\_\_\_ Name and Address of Physician

\_\_\_\_\_ Give names of all other Physicians consulted

\_\_\_\_\_ Hospitalized From: To:

\_\_\_\_\_ Name and Address of Hospital

\_\_\_\_\_ Are you covered by any other medical insurance policy? Yes \_\_\_\_\_ No \_\_\_\_\_ if Yes, Please provide name and address of other Insurance Company.

\_\_\_\_\_ Policy Number: \_\_\_\_\_

## AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

TO: Any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder or benefit plan administrator.

I AUTHORIZE you to release to the Company or its representatives, any and all information concerning advice, care or treatment provided the patient, or deceased, including information relating to mental illness, use of drugs or use of alcohol. I also authorize the group policyholder or benefits plan administrator to provide to the Company or its representatives with insurance coverage information including benefits paid or payable, financial information or employment related information. I UNDERSTAND that the information released under this authorization will be used for the purpose of evaluating and processing a claim for benefits. I authorize the Company to disclose the information for that purpose to the group policyholder or its representatives, to any reinsurer, and to any other insurer or self-insurer to whom a claim for benefits may be submitted. This disclosure will include benefits paid or copies of checks/drafts.

I also AUTHORIZE the Company to disclose the information to any person performing a business or legal function for its benefit, and to any person who has an authorization specifically permitting the disclosure.

I AGREE that the authorization shall be valid from the date signed for the duration of the claim.

I know that I have a right to request to receive a copy of this authorization. A photocopy of this authorization shall be as valid as the original.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date Signed