Statement of Claim

ASSOCIATION AND SOCIETY INSURANCE CORPORATION

ASI
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INSURANCE CORPORATION

P.O. Box 2510
Rockville, Maryland 20847-2510
1-800-638-2610 (Insureds Only)
301-816-0045 (All Others)

HOW TO SUBMIT A TRICARE CLAIM:

1. The form must be completed in full by the Member and;
2. Send the appropriate medical bills, hospital bills and all Explanation of Benefit worksheets from Tricare to: Claims Department, Group Insurance Administrator, P.O. Box 2510, Rockville, MD 20847-2510
3. Tricare claimants must submit a receipt from the provider of care showing the paid co-payment amount.

Employee's Name and Address

LAST FIRST INITIAL

STREET ADDRESS

CITY

STATE ZIP CODE ☐☐☐☐☐-☐☐☐☐

Certificate Number: _____

SEX: ☐ M ☐ F

Marital Status:
☐ Single ☐ Married ☐ Other_____

Date of Birth: _____/_____/_____

NAME OF EMPLOYER

Patient and Illness/Accident Information

Name of Patient: _____ Date of Birth: _____/_____/_____

Relationship to Member: ☐ Self ☐ Spouse ☐ Son ☐ Daughter Type of Claim: ☐ Hospital Indemnity ☐ Medical Indemnity ☐ Tricare

Nature of Accident or Illness – Describe:_____

Have you claimed benefits for this condition previously? ☐ Yes ☐ No ☐ If Yes when_____

Assignment of Benefits

I hereby authorize payment of eligible benefits under my policy in connection with this injury or illness directly to (enter name of provider of care: hospital, doctor, etc): _____

Signature (Insured) _____ Date _____

Please read the statement that applies to your state of residence and sign the bottom of this page.

For residents of all states EXCEPT: Arkansas, California, Colorado, Florida, New Jersey, New Mexico, Pennsylvania and Virginia: 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 substantial civil penalty where and to the extent allowed by state law.

For residents of Arkansas, New Jersey and New Mexico: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

FOR RESIDENTS OF CALIFORNIA: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading 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 damage. Any insurance company or its agent who knowingly provides false, incomplete, or misleading 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 shall be reported to the Colorado Division of Insurance.

For residents of Florida: 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 residents of Pennsylvania: 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.

Signature _____ Date _____