



THE FOURSQUARE CHURCH

2019-2020 Insurance Policy Information



Gallagher

Insurance | Risk Management | Consulting

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GUIDE. GUARD. GO BEYOND.

Disclaimer.....3

Insurance Contacts.....4

Foursquare Insurance Services Coverage Information.....5

Information For Securing Alternative Insurance Outside Of Foursquare Insurance Program.....6

 Benefits For Staying With Foursquare Insurance7

Certificates Of Insurance And Proof Of Insurance8

Volunteer Drivers And Private Vehicles.....9

 Permit For Volunteer Use Of Private Vehicle..... 10

Policy Information..... 11

 Commercial Package Insurance..... 12

 Excess Property..... 13

 Excess Liability 14

 Sexual Molestation..... 15

 Workers’ Compensation 16

 Automobile Liability 17

 Cyber Liability 18

 Boiler And Machinery..... 19

 Activities..... 20

Claims Procedures..... 21

 Claims Reporting Procedures..... 22

 Activities Claim Forms 23



DISCLAIMER

THE CONTENT PROVIDED WITHIN THIS PUBLICATION IS FOR INFORMATIONAL PURPOSES ONLY FOR THE ENTITIES WITHIN THE INTERNATIONAL CHURCH OF THE FOURSQUARE GOSPEL THAT PARTICIPATE IN THE FOURSQUARE INSURANCE SERVICES PROGRAM. IT IS NOT A LEGAL DOCUMENT AND SHOULD NOT BE CONSTRUED AS SUCH.

The coverages and exclusions listed under each line of insurance presented in this publication are not all-inclusive. For complete and detailed information, a copy of the entire policy can be obtained by written request by email: Foursquare.GGB@ajg.com



INSURANCE CONTACTS



NAME	PHONE	EMAIL	POSITION
<p>Claims Client # 005053 Toll-free: 1-844-297-0850 E-mailing new claims directly to The Network at TNWCLAIMS@TNWINC.COM After Hours <i>Emergency</i> Phone Number: 1-800-452-5452</p>			
Shannon Mcvey	D: 916-576-8239	Shannon_Mcvey@gbtpa.com	Account Manager External TPA
Lauren Zambelli	D: 630-285-3431 M: 847-814-8703	Lauren_Zambelli@gbtpa.com	Account Executive
Anthony McLaughlin	D: <u>630-285-5963</u> M: <u>402-216-6083</u>	Tony_McLaughlin@gbtpa.com	Vice President - Religious & Nonprofit
<p>Insurance – Customer Service Toll-free: 833-813-5580 Office Hours 8Am to 5PM Eastern Time, email: Foursquare.GGB@ajg.com After hours certificate requests email: certrequests@ajg.com</p>			
Maria Perez	D: 305-639-3136	Maria_Perez@ajg.com	Area Senior V.P.
Ampy Jimenez	D: 786-331-1269	Ampy_Jimenez@ajg.com	Customer Service
Lorena Vandama	D: 305-639-3139	Lorena_Vandama@ajg.com	Customer Service
Virginia Ramirez	D: 305-639-3125	Virginia_Ramirez@ajg.com	Customer Service Assistant
Annie Toombs	D: 786-331-1254	Annie_Toombs@ajg.com	MVR and Certificate Requests
Tara Morrone	D: 561-998-6793	Tara_Morrone@ajg.com	Flood Unit Leader



Coverage is provided through the following carriers:

Commercial Package **Old Republic Insurance Company** **Policy Number:** 8219001080548
Includes: Property, General Liability, Excess Auto Liability, Errors & Omissions, Directors' & Officers', Misc. Professional, Harassment, Employee Benefits and Employment Practice Liability.

Excess Property **Lloyd's of London** **Policy Number:** B1262PW0068019
B1262PW0259019
B1262PW0259219
B1262PW0259119

Great American Insurance Company **Policy Number:** CPP030745308

Excess Liability **Lexington Insurance Company** **Policy Number:** 023627703
Berkshire Hathaway Specialty Insurance **Policy Number:** 42XSF30766601
StarStone National Insurance Company **Policy Number:** K88801190ALI

Sexual Molestation **Beazley Insurance Company, Inc.** **Policy Number:** BO391IR902611

Workers' Compensation **Zurich American Insurance Company** **Policy Number:** WC188553900

Auto Liability **Zurich American Insurance Company** **Policy Number:** BAP188553800

Activities **Arch Insurance Company** **Policy Number:** 11SPR0931600

Cyber Liability **Beazley Insurance Company, Inc.** **Policy Number:** W26FC1190101

Boiler and Machinery **Continental Casualty Company** **Policy Number:** R6076083374

Terrorism & Sabotage Ins. **Underwriters at Lloyd's London** **Policy Number:** UTS256272319

Every Foursquare church has the option of obtaining insurance coverage in the commercial market rather than participating in the Foursquare insurance program.

Each Foursquare church shall maintain adequate insurance on all church properties and activities. This obligation shall be the joint responsibility of the pastor and the members of the church council. It is recommended that every Foursquare church insure church properties and activities with the Foursquare Insurance Program, handled through its insurance services department. If the coverage is not written through Foursquare Insurance Services, the following requirements must be satisfied:

Copies of all insurance policies shall be filed with the insurance services department.

Advance notification must be given to the insurance services department so that the Foursquare policy can be canceled in time to not overlap with the outside policy premium. A proposal must be sent to Foursquare insurance prior to binding with an outside carrier.

All auxiliary activities and endeavors of the church shall be properly covered.

The policies shall be placed preferably with A++ or A+ carriers, as listed in A. M. Best’s insurance guide. Reciprocal or assessable mutual companies are not acceptable.

The first named insured is the “legal” name of the church and not the slogan name. Or it can be the legal name dba the slogan name.

International Church of the Foursquare Gospel must be listed as **“Additional Insured.”**

On property ICFG is to be named **“Loss Payee.”**

The policy needs an endorsement with **“Primary Non-Contributory”** wording.

Currently **State Farm Insurance** is not an approved carrier as their sexual misconduct coverage does not meet Foursquare requirements.

The amounts of **coverage required by the ICFG Board** are listed below:

Coverage Type	Minimum Coverage Limits
General Liability	1,000,000
Abuse and Molestation	1,000,000
Workers' Compensation	State Statutory Limit
Activities	10,000 - On and Off Premises Coverage Required Crime (internal) 10,000
Auto Liability	300,000/500,000
Directors & Officers	1,000,000
Employment Practices Liability	1,000,000
Property and Contents	100% replacement cost value
No earthquake coverage required	
If building is in FEMA flood zone - National Flood Insurance is required	

Please note that in order to be removed from the Foursquare insurance program, all the requirements stated above must be met. If the policies do not meet the requirements, the church will continue to be enrolled in the Foursquare insurance program and be expected to pay the monthly assessment. In order for the insurance services department to determine if all of the requirements have been met, a copy of the complete policy must be submitted for review. In addition, if all the requirements have been met and the church is removed from the Foursquare insurance program, it is the church’s responsibility to inform their insurance broker that the International Church of the Foursquare Gospel, 1910 W. Sunset Blvd., Ste. 200, Los Angeles, CA 90026-0176 location is to be added as an additional insured.



BENEFITS FOR STAYING WITH FOURSQUARE INSURANCE

- A. Liability and Property insurance coverage levels are higher than required when a church stays with Foursquare insurance.
- B. Our broker handles all of your policy acquisitions each year.
- C. You will not be cancelled if for some reason you are late or you miss a payment; of course, it must be paid eventually.
- D. You will never be cancelled as a result of the number or dollar amount of losses.
- E. Annual policy renewals are automatic with Foursquare.
- F. Under the Foursquare plan the local church is given a professional claims administrator to advocate for the church on difficult claims.

QUESTIONS? Call our broker: Gallagher at 833-813-5580



Certificate of Participation:

The certificate of participation will be provided each year upon renewal for your internal use.

Certificate of Insurance:

If the inquiring party wants "evidence," or to be named as an "additional insured", a "certificate of insurance" needs to be requested from our broker.

Depending upon the type of certificate needed, there is a form in this section to request a "property certificate", and a form to request a "general liability certificate." Both forms are available on the following two pages. Once the forms are filled out, please scan and email to Foursquare.GGB@ajg.com or fax to 305-716-3293. The liability and property certificate request forms will be located in the foursquare website https://thehub.foursquare.org/Prod/FoursquareLeader/Content/Support/Insurance_Update.aspx?WebsiteKey=a380e0dc-2780-4202-9033-2a299f55c5f9

If there is correspondence from the requesting party or a copy of the rental agreement, lease or settlement papers, please scan and email or fax the information. Please keep in mind that all property transactions, including a month- to-month rental agreement, have to be sent through the board of directors prior to requesting a certificate.

Please fill in all the necessary fields on the form by either typing it or using a black pen and print using block lettering. This will avoid any unnecessary delays in issuing the certificate. All certificate requests must be submitted in the church legal name and have the 5 or 6-digit church ID code filled in.

Once the form is completed, it can be scanned and emailed, faxed, or mailed to the address near the bottom of the forms.

A request for a general liability certificate for a church event will only be approved if the church's account is current. The certificate will not be issued until the matter has been resolved.

If you need a certificate for proof of vehicle insurance, it must be requested through our broker. Call 833-813-5580 to request a form.

NOTE: All requests must be sent 72 hours prior to the final date needed. For emergency situations, please be aware that there is a 24-hour processing schedule, and every effort will be made to have the certificate issued in a timely manner.

Fax No: 305-716-3293

Phone: 833-813-5580



VOLUNTEER DRIVERS AND PRIVATE VEHICLES

It is not unusual for churches to permit volunteer drivers to use their personal vehicles for church activities such as youth outings. The Foursquare Insurance Services Department is concerned for the safety of everyone participating in a church activity. Therefore, we recommend that every precaution be taken when considering the use of volunteer drivers.

The Foursquare Insurance Services department recommends the following guidelines:

1. The volunteer driver should not be younger than twenty-five (25) years of age.
2. The church should request a copy of the volunteer driver's motor vehicle record (MVR) prior to allowing him or her to drive for a church activity.
3. The church should conduct a background check on the volunteer driver if minors are being transported.
4. The volunteer driver must show proof of vehicle insurance. It is recommended that the driver carry a minimum of 100,000/300,000/50,000, along with a minimum of 25,000 in medical pay per person.
5. Complete the "permit to volunteer use of private vehicle" shown on the next page for each volunteer driver.

NOTE: If the volunteer is to drive a church-owned vehicle, they must be added to the church's account prior to using the vehicle. Please see the instructions on how to add a driver to the church's account under "Commercial Vehicle Insurance."

PERMIT FOR VOLUNTEER USE OF PRIVATE VEHICLE

ANY PERSON USING A PRIVATELY OWNED VEHICLE TO TRANSPORT PASSENGERS FOR ANY CHURCH-SPONSORED PRIVATE VEHICLE MINIMUM RECOMMENDATIONS

◆ Insurance

One person bodily injury/aggregate bodily injury: \$100,000/\$300,000 per accident
Property Damage: \$50,000 per accident
Medical Payments: \$25,000 per person, per accident

◆ Number of Passengers (excluding the driver)

The number of passengers to be transported in any one vehicle shall not be more than the legally permitted number of passengers deemed appropriate as determined by the number of working seatbelts. Double-buckling is not permitted. All passengers are required to wear a seatbelt at all times while the vehicle is in transit.

Name of Driver: _____ Cell Phone #: _____

Drivers' License #: _____ Expiration Date: _____

Insurance Information:

Table with 2 columns and 5 rows: Name of Insurance Company, Policy Effective Dates, Bodily Injury Limits, Property Damage Limits, Medical Payments

Vehicle Information: Year: _____ Make: _____ Model: _____ License Plate: _____

As a volunteer, I am responsible for the safe operation of my vehicle and the safe transportation of the occupants. In the event of an accident, my personal vehicle insurance is primary. My insurance company will be responsible for settling all claims and/or lawsuits in the event of an accident.



POLICY INFORMATION



COMMERCIAL PACKAGE INSURANCE

Description of Policy: Includes Property, Crime, Automobile Liability, General Liability, Errors and Omissions Liability, Employee Benefits Liability and Employers' Liability.

Carrier: Old Republic Union Insurance Company

Policy Number: 8219001080548

Term: 05/01/2019-05/01/2020

Major Exclusions including,
(but not limited to the following):

- 1) Exclusion – Named Storm
- 2) Exclusion – Earthquake
- 3) Exclusion - Flood

Maintenance deductibles:

- Property \$5,000 per occurrence.
 - The entity pays \$2,500 if their assets are valued at \$250,000 or more and \$1,000 if less. Foursquare pays the rest.
- Crime \$500
- Activities is \$250
- Other policies: \$0

Claims Procedures:

Client # 005053

Toll-free: 1-844-297-0850

E-mailing new claims directly to The Network at TNWCLAIMS@TNWINC.COM

After Hours *Emergency* Phone Number: 800-452-5452

This is not an exact representation of what is in the policy, please refer to policy for all terms, conditions, limits, sub-limits, endorsements and exclusions.

EXCESS PROPERTY

Description of Policy: Excess Property

Carriers: Lloyd's of London
Great American Insurance Company

Policy Numbers: B1262PW0068019
B1262PW0259019
B1262PW0259219
B1262PW0259119
CPP030745308

Term: 05/01/2019-05/01/2020

Major Exclusions incl. but not limited to the following:

1. Earth Movement
2. Flood
3. Ordinary Payroll
4. Extended Period of Indemnity
5. Excludes Pollution/Contamination
6. Excludes Asbestos
7. Excludes Mold
8. Excludes Nuclear, Biological or Chemical

Claims Procedures:

Client # 005053

Toll-free: 1-844-297-0850

E-mailing new claims directly to The Network at TNWCLAIMS@TNWINC.COM

After Hours *Emergency* Phone Number: 800-452-5452

This is not an exact representation of what is in the policy, please refer to policy for all terms, conditions, limits, sub-limits, endorsements and exclusions.



EXCESS LIABILITY

Description of Policy:	Excess Liability policy includes 3 layers of coverage.
Carriers:	1) Lexington Insurance Company 2) Berkshire Hathaway Specialty Insurance 3) StarStone National Insurance Company
PolicyNumbers:	1) 023627703 2) 42XSF30766601 3) K88801190ALI
Term:	05/01/2019-05/01/2020
Major Exclusions incl. but not limited to the following:	Violation of Communication or Information Law Exclusion Securities Exclusion Professional Services Exclusion
Claims Procedures:	Client # 005053 Toll-free: 1-844-297-0850 E-mailing new claims directly to The Network at TNWCLAIMS@TNWINC.COM After Hours <i>Emergency</i> Phone Number: 800-452-5452

This is not an exact representation of what is in the policy, please refer to policy for all terms, conditions, limits, sub-limits, endorsements and exclusions.



SEXUAL MOLESTATION

Carrier: Beazley Insurance Company, Inc.

PolicyNumber: BO391IR902611

Term: 05/01/2019-05/01/2020

Major Exclusions incl. but not limited to the following: Knowledge of Perpetrator, Nuclear Incident, Radioactive Contamination, Sanction Limitation and Exclusion, War and Terrorism

Claims Procedures:

If your organization has been notified of an allegation of sexual misconduct or abuse, regardless of whether a law-suit has been filed or not, it is imperative that you notify one of the following persons immediately:

- Corporate Legal Counsel: 213-989-4211
Foursquare Insurance Services Manager: 213-989-4435
Foursquare Senior Claims Administrator: 213-989-4403

Any inquiries from news media should be immediately referred to the corporate Legal counsel for response. Do not admit liability.

If this involves an adult/minor, for more information please refer to the Foursquare Child and Youth Protection Policy Manual.

This is not an exact representation of what is in the policy, please refer to policy for all terms, conditions, limits, sub-limits, endorsements and exclusions.



WORKERS' COMPENSATION

Description of Policy: Workers Compensation policies with a deductible program of \$250,000 and retrospective rating program.

Carrier: Zurich American Insurance Company

Policy Numbers: WC187890300
WC188553900

Term: 05/01/2019-05/01/2020

Limit: Workers Compensation- Statutory

Major Exclusions incl. but not limited to the following: Intoxication – Alcohol or Drug abuse
Suicide

Claims Procedures: **Client # 005053**
Toll-free: 1-844-297-0850
E-mailing new claims directly to The Network at TNWCLAIMS@TNWINC.COM
After Hours *Emergency* Phone Number: 800-452-5452

This is not an exact representation of what is in the policy, please refer to policy for all terms, conditions, limits, sub-limits, endorsements and exclusions.



AUTOMOBILE LIABILITY

Description: Auto Liability

Carrier: Zurich American Insurance Company

Policy Number: BAP188553800

Term: 05/01/2019-05/01/2020

Major Exclusions including,
but not limited to the following: Nuclear Energy Liability Exclusion
Knowledge of Occurrence
Auto Physical Damage

Claims Procedures: **Client # 005053**
Toll-free: 1-844-297-0850
E-mailing new claims directly to The Network at TNWCLAIMS@TNWINC.COM
After Hours *Emergency* Phone Number: 800-452-5452

This is not an exact representation of what is in the policy, please refer to policy for all terms, conditions, limits, sub-limits, endorsements and exclusions.



CYBER LIABILITY

Description:	Cyber insurance covers your business' liability for a threat involving sensitive customer information or identity theft, such as Social Security numbers, credit card numbers, account numbers, driver's license numbers and health records.
Carrier:	Beazley Insurance Company, Inc. (Syndicate 2623/623 at Lloyd's)
PolicyNumber:	W26FC1190101
Term:	05/01/2019-05/01/2020
Major Exclusions including, but not limited to the following:	War and Civil War Exclusion Asbestos, Pollution, and Contamination Exclusion Endorsement Nuclear Incident Exclusion Radioactive Contamination Exclusion
Claims Procedures:	If you suspect a threat, immediately contact Beazley Insurance Group: Email: bbr.claims@beazley.com Phone: (866) 567-8570 (24 Hours)

This is not an exact representation of what is in the policy, please refer to policy for all terms, conditions, limits, sub-limits, endorsements and exclusions.



BOILER AND MACHINERY

Description:	Coverage for boiler and machinery inspections and for loss due to mechanical or electrical breakdown of nearly any type of equipment, including photocopiers and computers. Coverage applies to the cost to repair or replace the equipment and any other property damaged by the equipment breakdown.
Carrier:	Continental Casualty Company
PolicyNumber:	R6076083374
Term:	05/01/2019-05/01/2020
Major Exclusions including, but not limited to the following:	Ordinance or Law Nuclear Hazard War or Military Action Water "Fungus", Wet Rot and Dry Rot
Maintenance deductibles:	The entity pays \$2,500 if their assets are valued at \$250,000 or more and \$1,000 if less. Foursquare pays the rest.
Claims Procedures:	Immediately contact CNA: Email: lossreport@cnaasap.com Phone: 877-262-2727 Fax: 800-953-7389

This is not an exact representation of what is in the policy, please refer to policy for all terms, conditions, limits, sub-limits, endorsements and exclusions.



ACTIVITIES

Policy Description:	This policy is secondary to any other applicable group medical insurance. It pays for accidental/medical expenses for an injury to church members, including dependents and invited guests while taking part in a church-sponsored and supervised activity. This would include scheduled and non-scheduled sports. Coverage is extended while on the church's premises, as well as off site. No lost wages will be paid to the injured person.
Carrier:	Arch Insurance Company
Policy Number:	11SPR0931600
Term:	05/01/2019-05/01/2020
Deductible:	\$250 per claim if claimant has no health insurance. NOTE: This is the responsibility of the claimant. The carrier will advise where, when and to whom it is payable.
Claims Procedures:	Please refer to the Activities claim forms below.

This is not an exact representation of what is in the policy, please refer to policy for all terms, conditions, limits, sub-limits, endorsements and exclusions.

CLAIMS PROCEDURES



CLAIMS REPORTING PROCEDURES

NAME	PHONE	EMAIL	POSITION
<p>CLAIMS Client # 005053 Toll-free: 1-844-297-0850 E-mailing new claims directly to The Network at TNWCLAIMS@TNWINC.COM After Hours <i>Emergency</i> Phone Number: 800-452-5452</p>			
Shannon McVey	D: 916-576-8239	Shannon_Mcvey@gbtpa.com	Account Manager External TPA Claims Program Manager
Lauren Zambelli	D: 630-285-3431 M: 847-814-8703	Lauren_Zambelli@gbtpa.com	Account Executive
Anthony McLaughlin	D: 630-285-5963 M: 402-216-6083	Tony_McLaughlin@gbtpa.com	Vice President - Religious & Nonprofit



Medical Expense Claim Form



Claims Department: Executive Plaza IV, 11350 McCormick Road, Suite 102, Hunt Valley, MD 21031

Phone No: 1-888-259-3236 | **Fax:** 443-279-2901 |

Email: claims@archinsurancesolutions.com

Medical Expense Claim Instructions

Your policy provides excess medical insurance coverage providing benefits in excess of the benefits provided under your primary medical insurance policy. A Medicare Supplement policy would be considered a primary insurance policy. As such, you must first file your claim with your primary medical insurance company. If you are not fully reimbursed by your primary insurance company, you may file a claim for the unpaid medical expenses as noted in these instructions.

Please complete and sign the Medical Expense claim form in full and return it with the documentation noted below.

For all claims, submit:

- Copies of invoices or receipts for all claimed medical expenses. Invoices should show the date of service; the office or facility where the service was provided; the condition treated and the nature of the treatment received.
- Proof of payment of the claimed medical expenses – copies of both sides of checks, copies of credit card statements or receipts for cash payments;
- Proof of loss:
 - An attending Physician's Statement completed by the patient's primary treating physician;
 - Medical records or other documentation showing the nature of the condition and the treatment received;
 - Copies of Explanations of Benefits from your primary insurance company showing any claims paid or denied;

Your claim should be submitted to the address at the top of these instructions.

19-03-AH3 Medical Expense Claim

Medical Expense Claim Form



Claims Department: Executive Plaza IV, 11350 McCormick Rd., Suite 102, Hunt Valley, MD 21031
Phone No: 1-888-259-3236 | **Fax:** 443-279-2901
Email: claims@archinsurancesolutions.com

Section 1: Claiming Benefits

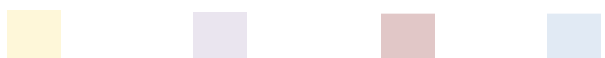
To Be Completed by Policy Holder Claiming Benefits	
Insured Individual	Policy No. 11SPR0931600
Group Plan or Program	Certificate / I.D. Number
Phone No.	Date of Birth Male <input type="checkbox"/> Female <input type="checkbox"/>
Address	
Email Address	
Do you have other medical insurance that may provide coverage for this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, has a claim been submitted to the other insurance company? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Other Insurance Company	Phone Number of Other Insurance Company
Address of Other Insurance Company	
Primary Insurance Carrier	Policy No.
Secondary Insurance Carrier	Policy No.
Date injury occurred or when symptoms began	Date first treated for this illness or injury
If injured in play or practice of a sport, indicate the sport:	
Explain when and where injury occurred or illness began	
Describe nature and diagnosis of illness or injury	
<p><u>INSURED OR PARENT MUST SIGN BELOW</u></p> <p>Authorization: I hereby authorize release to Arch Insurance Company any and all information concerning advice, care or treatment provided to myself or any of my family, which may be needed to process this claim.</p> <p>Arch Insurance Company does not share private health information except as required or permitted by law. We are committed to guarding the private information entrusted to us.</p>	<p><u>IF PAYMENT IS TO BE ASSIGNED TO PROVIDER, SIGN BELOW</u></p> <p>Authorization: I hereby authorize payment of medical benefits to the medical provider identified on this form, for the service described.</p>
Insured's Signature:	Insured's Signature:
Date:	Date:
Physician or Provider Information (Please Attach Universal 1500 Form or Fill Out in Full Below)	

Medical Expense Claim Form



Date of First Symptom of Illness or Injury			Date First Consulted You For This Conditions		
Has patient ever had same or similar symptoms?					Yes <input type="checkbox"/> No <input type="checkbox"/>
Diagnosis					
History of illness or injury					
Name of referring physician or other source					
For services related to hospitalization (Give date)			Admitted		
			Discharged		
Name and address of facility where services rendered					
Was laboratory work performed outside your office?				Lab charges	
Yes <input type="checkbox"/> No <input type="checkbox"/>					
Date of Service	Place of Service	CPT Code	Description of Service	ICD-9	Charge
Will you accept assignment?				Total Charges	
Yes <input type="checkbox"/> No <input type="checkbox"/>					
Provider's Signature				Date	
Print Provider's Name					
Provider's Address					
Telephone Number		Fax Number		Tax ID Number	

Part II - Please Print All Information



Medical Expense Claim Form



Have you been covered (as an insured or dependent) by any other hospital and/or medical plan for the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, indicate the name and address of the company _____ _____		
Effective date of coverage	Expiration Date	Policy Number
Have you filed a claim with any other insurance company? Yes <input type="checkbox"/> No <input type="checkbox"/>		
I hereby certify that the above information give by me in support of this claim is true and correct.		
Patient or Authorized Representative's Signature		Date
If Authorized Representative, Relationship to Patient		
or Legal Designation		
The following section is applicable if you are covered under any other medical insurance plan.		
Mother's Name		Policy Number
Employer's Name		Employer's Telephone Number
Employer's Address		
Name and Address of Insurance Company _____ _____		
Father's Name		Policy Number
Employer's Name		Employer's Telephone Number
Employer's Address		
Name and Address of Insurance Company _____ _____		
Spouse's Name		Policy Number
Employer's Name		Employer's Telephone Number
Employer's Address		
Name and Address of Insurance Company _____ _____		



Medical Expense Claim Form



Claims Department: Executive Plaza IV, 11350 McCormick Rd., Suite 102, Hunt Valley, MD 21031
Phone No: 1-888-259-3236 | **Fax:** 443-279-2901
Email: claims@archinsurancesolutions.com

Section 2 - Claimed Expenses

Please list all medical expenses incurred as a result of this sickness or injury. Enclose copies of medical bills, reports and explanations of benefits from your Primary and Supplemental insurance companies.

<i>Claimed Expenses</i>					
Name of Provider	Date of Service	Type of Service	Amount of Bill	Amount paid by other Insurance	Amount Claimed
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable by law.

I have read the foregoing, and the above answers are true and complete according to the best of my knowledge and belief.

Signature of Claimant

Date



The laws of some states require us to furnish you with the following notices:

WARNING. Any person who knowingly:

Alaska: and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona, Arkansas and Rhode Island: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or specific to AR and RI: presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Delaware: and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: 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: and with intent to injure, defraud, or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky, New York and Pennsylvania: and with intent to defraud any insurance company or other person files an application for insurance, or files a statement of claim, containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime, specific to PA: subjects such person to criminal and civil penalties and specific to NY: 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.

Louisiana, New Mexico, Texas and West Virginia: presents a false or fraudulent claim for the payment of a loss (or specific to LA, TX and W VA: who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (or specific to NM: to civil fines and criminal penalties.)

Maryland: and willfully presents a false or fraudulent claim for payment of loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: with 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 is guilty of insurance fraud.

Oklahoma: and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto, may be subject to prosecution for insurance fraud.

Puerto Rico: and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

WARNING:

Colorado: 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.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maine/Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

Tennessee and Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurer or insurance company for the purpose of defrauding the insurer or insurance company. Penalties include imprisonment, fines and denial of insurance benefits.



Authorization to Disclose Information

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Arch insurance Company, or it's authorized representative, Administrative Concepts Inc. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past.

To any insurance company, any travel organization or agency, airline carrier, cruise line, your operator, rental agency, hotel, motel, or similar entity providing lodging on a rental / lease basis or any other person who may have knowledge regarding this claim: I authorize the release any information requested regarding this claim and the loss reported.

The company will use this information to determine if any claim is eligible. Any information obtained will not be released by the Com- pany except to my primary health insurance carrier (if any) or persons or organizations performing investigation or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effect and valid as the original and shall remain in effect for one year from the date of authorization.

I certify that the information given by me in support of my claim is true and correct. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution or insurance fraud.

Patient's or Authorized Representative's Signature

Date

If Authorized Representative, Relationship to Patient

or Legal Designation

