



AMERICAN SENTINEL INSURANCE COMPANY

2407 Park Drive, P.O. Box 61140, Harrisburg, PA 17106-1140
Phone: 717-540-0600 Toll Free: 1-800-692-7338 Fax: 717-657-9499
E-mail: gapclaims@aegisfirst.com

GAP POLICY

To File A Claim: Complete Information and attach a copy of the Explanation of Benefits (EOB) from your Primary Carrier.

1. Full Name (Employee)		2. Employee's Date of Birth (MO.,DAY,YR.) / /		3. Sex
4. Address			5. Social Security Number	
6. City	7. State	8. Zip	9. Employer	
10. Full Name (Patient)			11. Daytime Telephone Number () -	
12. Patient's Date of Birth (MO., DAY, YR.) / /		13. Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Self <input type="checkbox"/> Other		

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 subject to criminal and civil penalties.

AUTHORIZATION TO RELEASE INFORMATION

I authorize American Sentinel Insurance Company of Pennsylvania (the Company) to acquire from and authorize any hospital, physician, medical practitioner, clinic, medically related facility, insurance company, or the Bureau of Motor Vehicles to release to the Company any information regarding me for the purpose of evaluating this claim. I authorize the Company to disclose all such information to any physicians, or any other insurance company in order to evaluate a claim.

This Authorization shall remain valid for a period of two years from the date signed. A photocopy of this Authorization will be as valid as the original. A copy of the Authorization is available upon request of the Company.

Date: _____ Signature _____

If a Minor, Signature of Parent or Guardian – Signature _____

If you would like the provider paid directly, please include original medical billing with the provider's Tax ID # and contact information.

Provider Name & Address	Provider Tax ID #
-------------------------	-------------------