

ACCIDENT AND ILLNESS CLAIM FORM

Seven Corners, Inc.
303 Congressional Blvd.
Carmel, IN 46032
800-335-0477 or 317-575-2656 Fax: 317-575-2256

Insurance Carrier:
Name of Group:
Policy Number:

Instructions:

- 1. This form is to be used when filing a claim for reimbursement of Medical Expenses and must be completed by the Insured in full.
2. Fully itemized bills including Claimant's Name, Nature of Illness/Injury, must be included with this claim form, if available.
3. Description and Charge for each service provided.
4. This form must be signed and dated in all applicable sections. In most cases, two signatures are required.
5. This form and all attached bills must be submitted to the address indicated above.

6. Submit a copy of your passport and student visa - only the pages with your photo are required.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Coverage Effective Date ___/___/___ Coverage Termination Date ___/___/___ E-Mail Address: _____

- 1.) Name of Insured: _____ Date of Birth ___/___/___ Sex: ___ Male ___ Female
2.) Name of Claimant: (PATIENT) _____ Date of Birth ___/___/___ Sex: ___ Male ___ Female
3.) Current Residence Address: _____
Daytime Phone Number: (_____) _____
4.) Permanent Address (In Home Country): _____
Date scheduled to return to Home Country: ___/___/___
5.) If Accident, provide details, i.e., how when and where accident occurred: _____
6.) If Illness, advise when and where symptoms first occurred and nature of illness: _____
7.) Did you treat at a student health center (yes/no)? ___ If yes, you must provide document of the date(s) of treatment for this condition with this form.
8.) Name and address of Consulting Physicians: _____
9.) Have you ever been treated for this Illness before? Yes ___ No ___ If Yes, when? _____
10.) Provide Name and Address of your Regular Physician in your Home Country: _____
11.) Please advise names of any prescription medications you are presently taking: _____
12.) Indicate other Health Insurance coverage, include name, address, policy number and certificate number of Insurer: _____

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator furnish to the Claims Administrator named above or its representatives, any and all information with respect to any injury or illness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, illness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrators to provide the Claims Administrator named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I, or my authorized representative, may request a copy of this authorization.

In addition, I hereby certify that the above information is true and correct to the best of my knowledge and belief. I have reviewed and understand the Fraud Notices on page 2 of this document.

__X__ (PATIENT) _____ __X__ _____ Date
Signature of Claimant or Parent, If Claimant is a Minor

Copies of your passport and either your I-20 or DS-2019 visa, or form I-94 MUST be submitted with the this claim form.

State Fraud Notices—
For Use On Applications and Claims Forms

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/or civil penalties.