INJURY AND ILLNESS PROOF OF LOSS FORM

Seven Corners, Inc.
303 Congressional Blvd.
Carmel, IN 46032
800-544-1802 or 317-582-2609 Fax: 317-575-2256

To be considered, proof of loss form and receipts for expenses must be submitted within 90 days of the date of service!

(INSTRUCTIONS) The Injury and Illness Proof of Loss Form MUST BE:

1. ***PRINTED & MAILED*** to the address mentioned above, **or *PRINTED & FAXED*** to (317) 575-2256 - Attention: Claims Department
2. **Scanned documents are accepted via e-mail to: claims@sevencorners.com**
3. ***Completed IN FULL*** by the Insured, to be considered for Medical Expense Payment.
4. ***SIGNED & DATED*** in all applicable sections. In most cases, 2 signatures are required.
5. Submit fully itemized bills, including a complete description of charges for each service provided, along with the Claimant's Name and Nature of the Illness.
6. ***If you would prefer reimbursement "outside the USA", be sure to complete PAGE 4.***

The furnishing of this form, or its receipt by the Company, must not be construed as an admission of any liability on the Company, or a waiver of any of the conditions of the insurance contract. Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

coverage information

Insurance Carrier: **Certain Underwriters at Lloyds**	Name of Group / Plan: **AfterCorps**	Policy / Certificate Number:
Coverage Effective Date *(month/day/year)* _____/_____/_____	Coverage Termination Date *(month/day/year)* _____/_____/_____	

insured information

Name of Insured *(last, first, middle initial, suffix)*:
Date of Birth *(month/day/year)* _____/_____/_____ Sex: ____ M ____ F

claimant information

Name of Claimant *(last, first, middle initial, suffix):*
Date of Birth *(month/day/year)* _____/_____/_____ Sex: ____ M ____ F

current address

Current Residence Address*(address, city, state, postal code, country):*	
Daytime Phone Number: (area and / or country code)	Email Address:

Have you submitted form CA-1 or CA-2 for consideration under worker's compensation, via the Federal Employees Compensation Act (FECA) for this condition? _____Yes _____No

medical information

If Injury, provide details, i.e., how, when and where injury occurred:
If Illness, advise when and where symptoms first occurred and nature of illness:
Name and address of Consulting or Treating Physicians:

Name of Claimant: (Last, first, middle initial, suffix)	Policy/Certificate Number

Coverage Effective Date *(month/day/year)*	Coverage Termination Date *(month/day/year)*
_____/_____/_____	_____/_____/_____

Have you ever been treated for this Illness or injury before? ____Yes ____ No	If Yes, when?

Indicate other Employer / Private / Government Medical 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, relative or benefit plan administrator to furnish to Seven Corners, Inc. 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 the claim and copies of all 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 identified above. I authorize the group policyholder, employer or benefit plan administrators to provide Seven Corners, Inc. with financial and employment related information and documents. I agree that I will provide Seven Corners, Inc. with any medical records, or other records, requested by Seven Corners, Inc. to process the claim. I understand that my failure to provide requested documents to Seven Corners, Inc. may result in denial of the claim. I understand that failure by any of the above referenced entities or individuals to provide information or documents to Seven Corners, Inc. may result in denial of the claim. In addition, I hereby certify that the above information is true and correct to the best of my knowledge and belief. I understand that any false statements made on this form or omissions of information requested by this form may result in denial of the claim. I acknowledge and understand the Fraud Notices on Page 3 of this document.

_____ _____

Signature of Claimant or Parent, If Claimant is a Minor Date

PHYSICIAN'S STATEMENT: – To be Completed by Physician Only

If treatment received outside United States please send medical report in place of this form.

Name of doctor: _____ Address: _____

Office phone #:( ) _____ Fax #: ( ) _____

Name of patient: _____ Age: _____

Date symptoms first appeared or accident occurred: _____

Date of first treatment: _____ Was patient treated by someone else? _____Yes _____No

If so, by whom? _____ When? _____

Has the patient received medication or other treatment for this condition, or for a related condition, by you or any other Physician during the 12 months immediately prior to the effective date of this policy (see above for effective date)? If so, please provide exact dates and details:

_____

_____

Any false or misleading statements made in support of and resulting in the payment of a claim shall be subject to legal action for collection of damages to the insurance company against the person or persons making such false and / or misleading statements.

Date Completed: _____ Physician's Signature: _____

Taxpayer ID Number: _____

FRAUD NOTICES

General: 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.

Alaska: A person who knowingly 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: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Maryland, West Virginia: 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Delaware, Idaho, Indiana: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: Warning: 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: 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.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine: 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.

Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another person files a 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 the person to criminal and civil penalties.

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

Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

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 section 638:20.

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

New Mexico: 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 civil fines and criminal penalties.

New York: 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, 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: WARNING: Any person who knowingly, 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: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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.

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

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

Claim Correspondence/Payment Instructions

primary information

Insured:	ID #:
Patient:	Email address:

correspondence information

Correspondence to US: ___Yes ___ No	Correspondence to Outside the US: ___ Yes ___ No
Phone # in the US:	Phone # Outside of the US:
Address in the US*(address, city, state, postal code)*:	Address Outside the US*(address, city, state, postal code, country)*:

payment information

Payments to be sent to:

Address in US: ___ Yes ___ No
Address outside the US ___ Yes ___ No
Bank account in the US*: ___ Yes ___ No *(If yes provide Banking Information in section below)*

bank information

Bank's name:	
Bank's Address: *(address, city, state, postal code, country)*	Bank's Phone #
Bank's Account:	Type of account:
Name on Account *(exactly as it appears on your bank statements)*:	IBAN Number and/or Swift Code ***(required** for wire transfers)*:
Bank currency for this account:	Bank routing/sort code:

*Checks cannot be sent to Banks **outside** the United States **Wire transfer for Banks **outside** the United States only (Greater than $50.00 USD)

Disclaimer:

I hereby authorize and request Seven Corners to mail any correspondence and/or payments to the above listed address. I further agree to release Seven Corners of any and liability in the event of lost or stolen correspondence/payments.

_____ _____

Signature of Insured Date

Optional for Insured's Convenience

I further agree to allow Seven Corners to send copies of explanation of benefit forms, copies of claim correspondence, and other confidential medical information about my claim or the claims of other insured's on my policy to the following email address: _____

_____ _____

Signature of Insured Date