SEVEN CORNERS
Travel Insurance

Medical Expense Claim Form

Helpful Tips

- If you have no other insurance, submit your medical bills that include the date of service, the billed amount, the type of service, and diagnosis. **Here's a guide to help you check that you have the correct supporting documents. »**
- If you have other insurance, we need the final statement from your other insurance company listing payment or denial of your claim with them (Explanation of Benefits or "EOB").
- Provide proof of your payment for medical treatment received (a credit card statement or if you paid cash a receipt from the medical provider showing you paid the charges).
- In most cases, a passport copy including entry/exit/visa stamps is required.
- Please complete all sections legibly and completely. If a question does not apply to you, please indicate "n/a".
- Send this signed form and any accompanying documents to Seven Corners within 90 days from the date of service using any of the methods listed to the right.

Call for help: 800-335-0611 (toll free)
or 317-575-2652 (worldwide)
or 317-818-2809 (collect)

Upload
Login to your account and upload your documents
sevencorners.com/login

Fax
317-575-2256

Email
claims@sevencorners.com
(email attachments cannot be larger than 25 MB.)

Disclaimer: The furnishing of this form, or its receipt 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 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: This information can be found on your Insurance I.D. Card

1 Insurance company	**2** Name of group/plan	**3** Policy/Certificate Number

Primary Insured Information

4 Name of Primary Insured (The person listed first on your plan.)	**5** Date of birth MM/DD/YYYY	**6** Gender: ☐ Male ☐ Female
7 Preferred phone number	**8** Fax number	
8 Preferred method of contact: ☐ Mail ☐ Email ☐ Phone		

Claimant/Patient Information ☐ Same as Primary Insured

9 Name of Claimant/Patient (The person suffering illness or injury.)	**10** Date of birth MM/DD/YYYY	**11** Gender: ☐ Male ☐ Female

Primary Insured's Permanent Address

12 Permanent Street Address		
13 City	**14** State/Province/Region	**15** Postal Code
16 Phone number	**17** Email address	
18 If applicable, date scheduled to return to home country. MM/DD/YYYY		

Primary Insured's Current Address ☐ Same as Permanent Address

19 Current Street Address		
20 City	**21** State/Province/Region	**22** Postal Code
23 Phone number	**24** Email address	
25 If applicable, date of arrival in U.S. MM/DD/YYYY		

26 Claimant/Patient Medical Expenses

****Provide proof of payment for medical treatment received (a credit card statement or if you paid cash, a receipt from the medical provider showing the charges you paid).*

Provider	Date of service	Amount charged	Amount paid (if applicable)

Claimant/Patient Medical Information

27 If Injured, provide details, such as how, when, and where injury occurred.		
28 Name of Claimant/Patient ☐ Same as Primary Insured	**29** Policy/Certificate number	
30 If illness, advise when and where symptoms first occurred and nature of illness.		
31 Name of consulting or treating physicians		
32 Street address of physician		
33 City	**34** State/Province/Region	**35** Postal Code
36a Have you ever been treated for this Illness before? ☐ Yes ☐ No	**36b** If YES, when were you treated? MM/DD/YYYY	
37 Name of your primary care physician in your home country.		
38 Street address of your primary care physician in your home country.		
39 City	**40** State/Province/Region	**41** Postal Code

Authorization For Release of Medical Information – To Be Completed by Claimant/Patient

In order to process a claim for benefits, I authorize any physician, hospital, or other Medical Provider to release to the Seven Corners Insurance Claims Administrator, or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed two and one-half years from the date signed. I understand I have a right to receive a copy of this authorization.

42 Date MM/DD/YYYY	**43** Signature of Person Suffering Illness or Injury or legally authorized representative

Physician's Statement – To Be Completed by Physician Only

44 Name of doctor	**44** Office phone number		**45** Office fax number
46 Office mailing address	**47** City	**48** State/Province/Region	**49** Postal code
50 Name of patient	**51** Date of birth MM/DD/YYYY		
52 Diagnosis that resulted in cancellation/interruption of trip			
53 Date symptoms first appeared or accident occurred MM/DD/YYYY	**54** Treatment dates MM/DD/YYYY Start: End:		
55a Was patient treated by anyone else? ☐ **Yes** ☐ **No**	**55b** If **YES**, by whom?		**55c** If **YES**, when? MM/DD/YYYY
56a Was patient prohibited to travel due to this illness/injury? ☐ **Yes** ☐ **No**	**56b** If **YES**, include dates patient was disabled from travel MM/DD/YYYY From: To:		
57 Date completed MM/DD/YYYY	**58** Physician's signature		

Other Insurance Coverage

59a Do you have any other travel or out-of-country insurance through employer, spouse's employer, retirement plan or credit card? ☐ Yes ☐ No	**59b** If **YES**, please indicate name of insurance company		
60 Address	**61** City	**62** State/Province/Region	**63** Postal Code
64 Policy Number	**65** Phone Number		

Claimant/Patient Prescriptions

66 List prescription medications you are taking or took during the past 6 months ***not*** related to your injury or illness.	**67** List prescription medications prescribed for your injury or illness.

IMPORTANT: PLEASE SIGN AND DATE BELOW. RETURN WITH PAGES 1, 2, 3, AND 5 OF THIS FORM. FAILURE TO DO SO MAY DELAY/HINDER THE PROCESSING OF YOUR CLAIM.

I AUTHORIZE any insurance company, physician, hospital, and other health care providers, any travel organization or agency, airline carrier, 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, to release any information requested regarding this claim and the loss reported.

I UNDERSTAND the information obtained by use of the authorization, will be used by Seven Corners to determine eligibility for benefits under this plan. Any information obtained will not be released by Seven Corners to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I further authorize.

I KNOW that I may request to receive a copy of the Authorization. I AGREE that a photographic copy of this authorization is as valid as the original. I AGREE that this Authorization shall be valid for two and one half years from the date shown below. I UNDERSTAND that it is illegal to knowingly file a false or fraudulent claim or to knowingly help someone else file one. I have read and understand the Fraud Notices on page 6 of this document.

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.

Insured's Signature	Print Name	Date

Payment Authorization Form

- To prevent any delays in claims handling, please be sure to sign this form.
- The ***Name*** in contact information must match exactly the name on the ACH, checking, or wire transfer account.
- Joint accounts require all names.

Contact Information

Name *Account Holder(s)*	Telephone		
Email address	I authorize Seven Corners, Inc. to contact me using this email address to discuss and/or inform me of payment confirmation. ☐ **Yes** ☐ **No**		
Mailing address (P.O. Boxes are not accepted)	City	State/Province/Region	Postal Code

1 Payment Type

☐ Check (check will ship to address above)

☐ ACH/EFT: US $ Canada(CAD) $ – complete section 2

☐ International Wire Transfer – complete section 3

2 U.S. Account Information

Account type: ☐ Checking ☐ Savings	Full Bank Name:		
Bank street address	City	State/Province/Region	Postal Code
ABA routing number	Account number	SWIFT BIC	

3 International/non-U.S. Account Information - Complete for payment through bank transfer outside the U.S.

Bank's full name			
Bank street address	City	State/Province/Region	Postal Code
Account number	Routing Number (BLZ, BSB, TRNO, branch code, etc.)		
IBAN	SWIFT BIC	Preferred reimbursement currency	

REGULATORY INFORMATION

Bank phone number	Identification number
	Account type: ☐ ID ☐ NIT ☐ RIF ☐ CPF ☐ CNPJ ☐ RUT ☐ CUIT ☐ OTHER

I hereby authorize Seven Corners, Inc. (hereinafter COMPANY) to mail any payments to the above listed address and to deposit any amounts owed me for reimbursement of relevant expenses or services rendered by initiating credit entries to my account at the financial institution (hereby BANK) indicated above. Further, I authorize BANK to accept and to credit any credit entries indicated by COMPANY to my account. In the event that COMPANY erroneously deposits funds in my account (by way of example, I am not entitled to the funds or the amount of deposit Is incorrect or such funds are deposited in the wrong account), I authorize COMPANY to debit or credit my account in the amount necessary to correct the initial deposit, but in no case shall any debit exceed the amount of the initial deposit. I further agree COMPANY is not responsible for any transaction fees charged and will release Seven Corners of any liability in the event of lost or stolen payments.

Account holder signature	Date

Claim Form Fraud Statement - For residents of all states other than those listed below:

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.

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.

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.

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 a loss is guilty of a crime and may be subject to fins 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.

FLORIDA WARNING :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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

KANSAS: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

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

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 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.

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 and 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.

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: 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.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose 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 payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: Any person who, with the 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 may have violated state law.

YOU DO NOT NEED TO RETURN THIS PAGE TO US