

Medical Expense Claim Form– You received medical treatment while on a covered trip.



1. 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.
2. 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").
3. 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).
4. In most cases, a passport copy including entry/exit/visa stamps is required.
5. If you are seeking reimbursement for payments already made, please complete the Payment Authorization Form on page 3.
6. Please complete all sections legibly and completely. If a question does not apply to you, please use N/A.

Not sending all the documents will delay the process of your claim.

Send this signed form and any accompanying documents to Seven Corners within 90 days from the date of service using any of the following methods:

MAIL Seven Corners, Inc. Attn: Claims 303 Congressional Boulevard Carmel, IN 46032 USA (Allow mail 7-10 days for delivery.)	UPLOAD Login to My Account and upload your documents www.sevencorners.com/myaccount#/login	FAX (+01) 317-575-2256	EMAIL eiaa.claims@sevencorners.com Email attachments can not be larger than 10 MB.
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Call for help: (317) 818-2097 and (844) EIIA360 or (844) 344-2360

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.

Claim Details

1 Please select the option that best describes your participation in the covered trip <input type="checkbox"/> Full-time employee <input type="checkbox"/> Faculty member on a sabbatical trip <input type="checkbox"/> Student/Participant of a Sponsored International Educational Program
2 Reason for claim (You may check both.) <input type="checkbox"/> Trip Cancellation <input type="checkbox"/> Trip Interruption

Coverage Information: This information can be found on your Insurance I.D. Card

3 Insurance company Starr Indemnity & Liability Company	4 Name of group/plan EIIA	5 Policy/Certificate Number LTG273330
6 Coverage effective date MM/DD/YYYY	7 Coverage Termination Date MM/DD/YYYY	

Institution in EIIA Program

8 Name of Institution (College, University, etc.)	9 Trip Start Date MM/DD/YYYY
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Claimant/Patient Information

10 Name of claimant	11 Date of birth MM/DD/YYYY	12 Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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Current Address

13 Current Street Address		
14 City	15 State/Province/Region	16 Postal Code
17 Daytime phone	18 Email address	
19 If applicable, date of arrival in U.S. MM/DD/YYYY		

Permanent Address

20 Current Street Address		
21 City	22 State/Province/Region	23 Postal Code
24 If applicable, date scheduled to return to home country. MM/DD/YYYY		

Medical Information

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

Other Insurance Coverage

40 Name other employer/private/government medical insurance coverage	41 Policy/certificate number	
42 Street address		
43 City	44 State/Province/Region	45 Postal Code

Prescriptions

46 List prescription medications you are taking or took during the past 6 months not related to your injury or illness.	47 List prescription medications prescribed for your injury or illness.
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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 4 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.

48 Signature of Patient/Claimant or Parent, If Claimant is a Minor	49 Date MM/DD/YYYY
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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 <i>Account Holder(s)</i>	Telephone		
Email address	I authorize Seven Corners, Inc. to contact me using this email address to discuss and/or inform me of payment confirmation. <input type="checkbox"/> yes <input type="checkbox"/> no		
Mailing address (P.O. boxes are not accepted)	City	State/Province/Region	ZIP/Postcode

1 Payment Type

<input type="checkbox"/> Check (check will ship to address above)	<input type="checkbox"/> ACH/EFT: US \$ Canada(CAD) \$ – complete section 2
<input type="checkbox"/> International Wire Transfer – complete section 3	

2 U.S. Account Information

Account type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Full Bank Name:		
Bank street address	City	State	Zip Code/Postcode
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	Zip Code/Postcode
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: <input type="checkbox"/> ID <input type="checkbox"/> NIT <input type="checkbox"/> RIF <input type="checkbox"/> CPF <input type="checkbox"/> CNPJ <input type="checkbox"/> RUT <input type="checkbox"/> CUIT <input type="checkbox"/> 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 medical 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
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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 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.

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.

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