

## 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:**

|  |   |                                  |   |
|--|---|----------------------------------|---|
| <b>MAIL</b><br>Seven Corners, Inc.<br><b>Attn: Claims</b><br>303 Congressional Boulevard<br>Carmel, IN 46032 USA<br>(Allow mail 7-10 days for delivery.) | <b>UPLOAD</b><br>Login to <b>My Account</b> and upload your documents<br><br><a href="http://www.sevencorners.com/myaccount#/login">www.sevencorners.com/myaccount#/login</a> | <b>FAX</b><br>(+01) 317-575-2256 | <b>EMAIL</b><br><a href="mailto:eiaa.claims@sevencorners.com">eiaa.claims@sevencorners.com</a><br><br>Email attachments can not be larger than 10 MB. |
|--|---|----------------------------------|---|

**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<br><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 ( <i>You may check both.</i> ) <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<br><b>Starr Indemnity &amp; Liability Company</b> | 4 Name of group/plan<br><b>EIIA</b>    | 5 Policy/Certificate Number<br><b>LTG273330</b> |
| 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 | 10 Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
|---|------------------------------|--|

### Claimant/Patient Information

|                     |                             |  |
|---------------------|-----------------------------|--|
| 11 Name of claimant | 12 Date of birth MM/DD/YYYY | 13 Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
|---------------------|-----------------------------|--|

### Current Address

|  |                          |                |
|--|--------------------------|----------------|
| 14 Current Street Address                            |                          |                |
| 15 City  | 16 State/Province/Region | 17 Postal Code |
| 18 Daytime phone                                     | 19 Email address         |                |
| 20 If applicable, date of arrival in U.S. MM/DD/YYYY |                          |                |

### Permanent Address

|  |                          |                |
|--|--------------------------|----------------|
| 21 Current Street Address  |                          |                |
| 22 City  | 23 State/Province/Region | 24 Postal Code |
| 25 If applicable, date scheduled to return to home country. MM/DD/YYYY |                          |                |

## Medical Information

|  |   |                |
|--|---|----------------|
| 26 If Injured, provide details, such as how, when, and where injury occurred.                                    |   |                |
| 27 Name of Claimant/Patient  | 28 Policy/Certificate number                  |                |
| 29 If illness, advise when and where symptoms first occurred and nature of illness.                              |   |                |
| 30 Name of consulting or treating physicians   |   |                |
| 31 Street address of physician   |   |                |
| 32 City  | 33 State/Province/Region                      | 34 Postal Code |
| 35a Have you ever been treated for this illness before? <input type="checkbox"/> Yes <input type="checkbox"/> No | 35b If YES, when were you treated? MM/DD/YYYY |                |
| 36 Name of your primary care physician in your home country.   |   |                |
| 37 Street address of your primary care physician in your home country.   |   |                |
| 38 City  | 39 State/Province/Region                      | 40 Postal Code |

## Other Insurance Coverage

|  |                              |                |
|--|------------------------------|----------------|
| 41 Name other employer/private/government medical insurance coverage | 42 Policy/certificate number |                |
| 43 Street address  |                              |                |
| 44 City  | 45 State/Province/Region     | 46 Postal Code |

## Prescriptions

|  |   |
|--|---|
| 47 List prescription medications you are taking or took during the past 6 months <i>not</i> related to your injury or illness. | 48 List prescription medications prescribed for your injury or illness. |
|--|---|

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.

|  |                    |
|--|--------------------|
| 49 Signature of Patient/Claimant or Parent, If Claimant is a Minor | 50 Date MM/DD/YYYY |
|--|--------------------|

# Payment Authorization Form

The **Name** in box 2 must match exactly the name on the ACH, checking, or wire transfer account. Joint accounts require all names.

## 1 Payment Type

|  |   |  |  |
|--|---|--|--|
| Method of payment:   |   |  |  |
| <input type="checkbox"/> International Wire Transfer – complete sections 2 and 4                     | <input type="checkbox"/> ACH: U.S. \$ – complete sections 2 and 3                   |  |  |
| <input type="checkbox"/> Check (check will ship to address in section 2) – complete sections 2 and 3 | <input type="checkbox"/> ACH: Canada \$, Euros & Pounds – complete sections 2 and 4 |  |  |

## 2 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 |

## 3 U.S. Account Information

|  |                |                 |     |
|--|----------------|-----------------|-----|
| Account type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings |                | Full Bank Name: |     |
| Bank street address  | City           | State           | ZIP |
| ABA routing number   | Account number | SWIFT BIC       |     |

## 4 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            | 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:<br><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 |
|--------------------------|------|

## Fraud Warnings & Disclosures

- 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.

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