Claim Filing Instructions

Read the instructions for the type of claim you need to file, you may have more than one.

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

Trip Cancellation

You were unable to depart on your covered trip.

1. Complete all applicable information starting on page 2.
2. If cancellation was the result of an illness/injury, please have the patient's physician complete the "Physician's Statement" on the attached form.
3. Please submit proof of payment for claimed expenses. Acceptable forms of proof of payment include a credit card statement and/or a copy of the front and back of the negotiated check.
4. Submit copies of the invoice/reservation for hotel, cruise, and tour bookings.
5. Submit your airline e-ticket if you have one.
6. Submit the travel supplier cancellation notice. This notice should contain the reservation/itinerary/booking information, date of cancellation, and the penalties.

If you are seeking reimbursement for payments already made, please complete the Payment Authorization Form on page 5.

Trip Interruption

You started on your trip and then had to return home due to an unforeseen event.

1. Complete all applicable information starting on page 2.
2. If the interruption was the result of an illness/injury, please have the patient's physician complete the "Physician's Statement" on the attached claim form – medical records from the date of service are applicable in lieu of a completed "Physician's Statement."
3. Please submit proof of payment for claimed expenses. Acceptable forms of proof of payment include a credit card statement and/or a copy of the front and back of the negotiated check.
4. Submit copies of all original invoice/reservations for hotel, cruise, and tour bookings.
5. Submit your airline e-ticket (please include original and new flight itineraries).
6. If you are seeking reimbursement for payments already made, please complete the Payment Authorization Form on page 5.

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

Call for help: (317) 818-2097 and (844) EIIA360 or (844) 344-2360

Claim Details

1 Please select the option that best describes your participation in the covered trip

☐ Full-time employee ☐ Faculty member on a sabbatical trip ☐ Student/Participant of a Sponsored International Educational Program

2 Reason for claim *(You may check both.)*

☐ Trip Cancellation ☐ Trip Interruption

Primary Insured's Information

3 Name of Primary Insured	**4** Date of birth MM/DD/YYYY		
5 Policy number LTG273330	**6** Preferred phone number		
7 Email address	**8** Fax number		
9 Mailing address (if different than home)	**10** City	**11** State	**12** Zip code
13 Home address	**14** City	**15** State	**16** Zip code
17 Preferred method of contact: ☐ Mail ☐ Email ☐ Phone			

Travel Supplier / Provider Information

18 Name of Institution (college, university, etc) in EIIA Program	**19** Phone number	**20** Confirmation/Booking number	
21 Institution mailing address	**22** City	**23** State	**24** Zip code
25 Date travel arrangements were made MM/DD/YYYY	**26** Date of initial payment for your land/sea/air arrangements MM/DD/YYYY		
27 Scheduled date of departure MM/DD/YYYY	**28** Scheduled date of return MM/DD/YYYY		
29 Actual date of return MM/DD/YYYY (trip interruption)			

Claimed Expenses

Category	Amount	Required Supporting Documents
30 Airfare	$	E-ticket receipt or original paper airline tickets
31 Lodging	$	Documents confirming your reservation/payment/partial payment
32 Tour(s)	$	Copy of the invoice
33 Cruise ship	$	Booking confirmation
34 Other	$	Meals, taxi, any additional expenses
35 Total expenses	$	
36 Refunds	$	Examples: account credits, cash refunds, trip or meal voucher, etc.
37 Total claimed	**$**	

38 If You Are Claiming Airline Tickets, Please Complete The Below Section

Your airline tickets may have value up to one year from the original scheduled departure date. Please indicate below whether you will be exchanging your tickets for another trip. Please note: Your signature on this agreement is not a guarantee of payment. Claim determinations are subject to the terms and conditions of the plan document.

☐ I (We) will not be using our airline ticket(s). Please enclose a copy of all electronic ticket confirmation(s).

☐ I (We) will be exchanging our airline ticket(s) for future travel. Please enclose a copy of all electronic ticket confirmation(s) along with documentation for the cost you incurred for the exchange.

Traveling Companions

39 Companion name	**40** Certificate number
41 Companion name	**42** Certificate number
43 Companion name	**44** Certificate number
45 Companion name	**46** Certificate number

47 Reason for Cancellation / Interruption

If Cancellation / Interruption Due To Medical Reasons

48 Name of person having sickness or injury	**49** Date of birth MM/DD/YYYY
50 Relationship to Primary Insured	
51a Has the person named in question 40 received medical attention for the mentioned symptoms or illness? ☐ **Yes** ☐ **No**	**51b** If **YES**, please indicate the date you were last treated MM/DD/YYYY
52 Period of Hospitalization (if applicable) MM/DD/YYYY From:	To:

Authorization For Release Of Medical Information – To Be Completed By 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.	
53 Date MM/DD/YYYY	**54** Signature (Signature of Person Suffering Illness or Injury or legally authorized representative)

Physician's Statement – To Be Completed By Physician Only

55 Name of doctor	**56** Office phone number		**57** Office fax number
58 Office mailing address	**59** City	**60** State	**61** Zip code
62 Name of patient	**63** Date of birth MM/DD/YYYY		
64 Diagnosis that resulted in cancellation/interruption of trip			
65 Date symptoms first appeared or accident occurred MM/DD/YYYY	**66** Date of first treatment for listed diagnosis MM/DD/YYYY		
67 Was patient treated by anyone else? ☐ **Yes** ☐ **No**	**67a** If **YES**, by whom?		**67b** If **YES**, when? MM/DD/YYYY
68 Was patient prohibited to travel due to this illness/injury? ☐ **Yes** ☐ **No**			
69 Date completed MM/DD/YYYY	**70** Physician's signature		

Documentation Requirements

71 Depending upon the circumstance involved in the loss, one or more of the following items may be required to complete the processing of your claim. Please place a check by those items you have attached. We recommend you keep copies of any items submitted with this claim.	
	Airline Ticket Stub/Receipt
	Copies of canceled checks or credit card statements with an invoice from your Travel Provider showing the date of your deposit. If you wish to waive the pre-existing condition exclusion on your claim, you must submit proof that you bought this insurance plan within 20 days of your first payment for air/land/sea arrangements.
	Police Report
	Statement from Hotel/Motel, Airline Carrier or Airport Facility that concerns your Cancellation. Note: Any cancellation of flight must be documented by the airline.
	Car Rental Agreement
	Copies of reimbursement statements issued by an airline carrier, airport facility, car rental agency, travel agent, hotel/motel or other similar establishment or any other insurance company providing reimbursement to you for the loss.
	Original purchase receipts for additional expenses
	Report from common carrier confirming cancellation
	Other (please describe)

Other Insurance / Authorization

72a Do you have any other travel or out-of-country insurance through an employer, spouse's employer, retirement plan or credit card? ☐ **Yes** ☐ **No**	**72b** If **YES**, please indicate name of insurance provider
73 Plan number	**74** Telephone

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 that Travel Benefits Plan, administered by Seven Corners, does not cover losses caused by injury or sickness to the extent that they are eligible under a primary group insurance, group-type insurance, prepayment, group practice or individual practice coverage and coverage other than school accident-type coverage, now therefore, as a condition for my receipt of immediate benefits under the Seven Corners plan, for claims in connection with injury or sickness beginning on the date shown above, I irrevocably agreed to: (a) assign all benefits payable from my primary insurer to Seven Corners; (b) promptly reimburse Seven Corners if and when I receive payment(s) from my primary insurance; (c) allow Seven Corners to file a claim with my primary insurer to receive direct reimbursement; and (d) when requested by Seven Corners, to furnish Seven Corners with copies of my primary insurer's schedule of benefits.

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.

75 Signature	**76** 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:

- ☐ International Wire Transfer – complete sections 2 and 4
- ☐ Check (check will ship to address in section 2) – complete sections 2 and 3
- ☐ ACH: U.S. $ – complete sections 2 and 3
- ☐ ACH: Canada $, Euros & Pounds – complete sections 2 and 4

2 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	ZIP/Postcode

3 U.S. Account Information

Account type: ☐ Checking ☐ 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: ☐ 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 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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