INJURY AND ILLNESS CLAIM FORM

Seven Corners, Inc.
303 Congressional Blvd.
Carmel, IN 46032
800-335-0477 or 317-575-2656 Fax: 317-575-2256

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

Instructions:

1. This form must be completed by the Insured in full to be considered for Medical Expense Payment.
2. Fully itemized bills including Claimant's Name, Nature of Illness/Injury, must be included with this claim form.
3. Description and Charge for each service provided.
4. This form must be signed and dated in all applicable sections. In most cases, two signatures are required.
5. This form and all attached bills must be submitted to the address indicated above.
6. If you would prefer reimbursement in Africa, complete Page 3. **Required for any reimbursement in Africa.**

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

Insurance Carrier:	Name of Group / Plan:	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: ( ) _____	Email Address:
If Applicable, Date of Arrival in U.S.: _____/_____/_____ *(month/day/year)* or ❑ N/A	

permanent address

Permanent Address In Home Country*(address, city, state, postal code, country)*:
If Applicable, Date scheduled to return to Home Country: _____/_____/_____ *(month/day/year)* or ❑ N/A

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:	
Have you ever been treated for this Illness before? ❑ Yes ❑ No	If Yes, when?
Provide Name and Address of your Primary Care Physician in your Home Country:	
Please advise names of any prescription medications you are presently taking:	
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 2 of this document.

_____ _____

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

State Fraud Notices—
For Use On Applications and Claims Forms

(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.

(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.

(Missouri) An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

(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.

(Puerto Rico) Any person who, knowingly and with the intent to defraud, presents false information inan insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

(Washington) Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."

(All Other States) 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/or civil penalties.

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 insureds on my policy to the following email address: _____.

_____ _____
Signature of Insured Date