

Claim Filing Instructions

Medical Expenses

You received medical treatment while on a covered trip.

1. Please complete all applicable information listed on the attached claim form.
2. If you have no other insurance, we need the original medical bills that include the date of service, billed amount, type of service, and diagnosis.
3. If you have other insurance, we need the final disposition from the primary insurer listing payment or denial of your claim with them (Explanation of Benefits or "EOB").
4. Proof of payment for medical treatment received (credit card statement or if paid in cash, provider receipt showing charges as paid).

Medical Expense Claim Form

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Primary Insured's Information

1a Name of Primary Insured (The person listed first on your plan)		1b Date of birth MM/DD/YYYY	
2a Companion name		2b Date of birth MM/DD/YYYY	
3 Preferred phone number		4 Email address	
3 Primary Insured's mailing address		4 City	5 State
7 Policy number		6 Zip code	
8 Policy valid MM/DD/YYYY - MM/DD/YYYY From:		To:	
9 Travel agency name			
10a Date of departure MM/DD/YYYY		10b Date of return MM/DD/YYYY	
11 Preferred method of contact: <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> Phone			

Incident Information

12 Date of occurrence MM/DD/YYYY		13 Date incident/accident report was filed MM/DD/YYYY	
14 Medical services requires as a result of: <input type="checkbox"/> Illness <input type="checkbox"/> Accident <input type="checkbox"/> Car accident <input type="checkbox"/> other			
15 If other, please explain			
16 Treatment received at: <input type="checkbox"/> Medical office / clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Emergency room <input type="checkbox"/> House call <input type="checkbox"/> Urgent care center <input type="checkbox"/> Dental Office <input type="checkbox"/> other healthcare professionals <input type="checkbox"/> Telemedicine/ telehealth			
17 Please briefly explain the medical reasons related to this claim			

18 Expenses

Name of service provider (physicians, clinic, hospital)	Date of service MM/DD/YYYY	Account or invoice No.	Amount billed	Total amount you paid
				\$
				\$
				\$
				\$

19a In the past have you received medical attention for the mentioned symptoms or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		19b If YES, please indicate the date you were last treated MM/DD/YYYY	
19c If YES, please indicate the name and address of the medical facility:			

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 Seven Corners, 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.

20 Date MM/DD/YYYY

21 Signature (Signature of Person Suffering Illness or Injury or legally authorized representative)

Physician's Statement – To Be Completed By Physician Only

22 Name of Doctor	23 Office phone Number	24 Office fax number	
25 Office mailing address	26 City	27 State	28 Zip code
29 Name of Patient	30 Age		
31 Diagnosis that resulted in cancellation/interruption			
32 Date symptoms first appeared or accident occurred MM/DD/YYYY	33 Date of first treatment for listed diagnosis MM/DD/YYYY		
34a Was patient treated by someone else? <input type="checkbox"/> Yes <input type="checkbox"/> No	34b If YES, by whom?	34c If YES, when? MM/DD/YYYY	
35a Was patient prohibited to travel due to this illness/injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	35b If YES, when? MM/DD/YYYY		
36 Date Completed MM/DD/YYYY	37 Physician's signature		

Other Insurance / Authorization

38a Do you have any other travel or out-of-country medical insurance through employer, spouse's employer, retired plan or credit card? <input type="checkbox"/> Yes <input type="checkbox"/> No	38b If YES, please indicate name of insurance company
39 Plan number	40 Credit card issuing bank

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 3 of this document.

41 Signature

42 Date MM/DD/YYYY

Send this form and any accompanying documents to Seven Corners 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 jhiaclaims@sevencorners.com
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Call for help: Local 1.317.582.2660 or Toll-free 1.866.888.7803