Claim Filing Instructions

MedicalExpenses

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	**6** Zip code
7 Policy number			
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: ☐ Mail ☐ Email ☐ 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: ☐ Illness ☐ Accident ☐ Car accident ☐ other	
15 If other, please explain	
16 Treatment received at: ☐ Medical office / clinic ☐ Hospital ☐ Emergency room ☐ House call ☐ Urgent care center ☐ Dental Office ☐ other healthcare professionals ☐ 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? ☐ **Yes** ☐ **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? ☐ Yes ☐ No	**34b** If **YES**, by whom?		**34c** If **YES**, when? MM/DD/YYYY
35a Was patient prohibited to travel due to this illness/injury? ☐ Yes ☐ 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? ☐ **Yes** ☐ **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	UPLOAD	FAX	EMAIL
Seven Corners, Inc. **Attn: Claims** PO Box 211379 Eagan, MN 55121 USA (Allow mail 7-10 days for delivery.)	Login to **My Account** and upload your documents **www.sevencorners.com/myaccount**	(+01) 317-575-2256	jhiaclaims@sevencorners.com

Call for help: Local **1.317.582.2660** or Toll-free **1.866.888.7803**