3 INTERNATIONAL HEALTH INSURANCE CLAIM FORM

Send Completed Claim Form To:
BlueCard Worldwide® Service Center
P.O. Box 72017
Richmond, VA 23255, USA

UNITED

If you have any questions on how to complete this form, call: 1-217-698-2100 or 1-800-535-9825

NOTICE TO ALL PARTIES COMPLETING THIS FORM: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.

PLEASE PRINT CLEARLY OR TYPE

1A. PATIENT INFORMATION — Copy this from your Blue Cross and Blue Shield identification card. Please see the instruction on the reverse side of this form before completing.

Please type or print ALPHA PREFIX: ___ ___ ___ GROUP NUMBER: ___ ___ ___ ___ ___ ___ IDENTIFICATION NUMBER: 0 0 0 ___ ___ ___ ___ ___ ___

1B. PATIENT'S NAME (First, middle initial, last)	**1C. PATIENT'S DATE OF BIRTH** MM/DD/YY / /	**1D. PATIENT'S SEX** ❑ Male ❑ Female
1E. NAME OF SUBSCRIBER (First, middle initial, last)	**1F. SUBSCRIBER'S DATE OF BIRTH** MM/DD/YY / /	**1G. PATIENT'S RELATIONSHIP TO SUBSCRIBER** ❑ Self ❑ Spouse ❑ Child

1H. SUBSCRIBER'S CURRENT MAILING ADDRESS

(Street, city, state, and country or ZIP code)_____

COMPANY ADDRESS CODE: ___ ___ ___ ___ ___ EMAIL ADDRESS:_____ TELEPHONE NUMBER:_____

Please provide in case we have questions about your claim

2. OTHER HEALTH INSURANCE — Is the patient covered under other health insurance, including Medicare A or B or National Health Insurance? ❑ Yes ❑ No

If yes, complete 2A through 2K below.

2A. NAME AND ADDRESS OF INSURING COMPANY

2B. TYPE OF POLICY	**2C. EFFECTIVE DATE**	**2D. TERMINATION DATE**	**2E. POLICY OR IDENTIFICATION NO. OF OTHER COVERAGE**
❑ Family ❑ Individual	MM/DD/YY / /	MM/DD/YY / /	

2F. TYPE OF COVERAGE	**2G. NAME OF SUBSCRIBER**	**2H. DATE OF BIRTH**
Medical: ❑ Yes ❑ No Mental illness: ❑ Yes ❑ No Hospital: ❑ Yes ❑ No		MM/DD/YY / /

2I. EMPLOYER OF SUBSCRIBER	**2J. EMPLOYMENT STATUS** ❑ Active employee ❑ Retired employee

2K. IF PATIENT IS COVERED UNDER MEDICARE, COMPLETE THE FOLLOWING: Medical Part A: ❑ Yes ❑ No Effective Date _____ Medical Part B: ❑ Yes ❑ No Effective Date _____

3. DIAGNOSIS — 3A. Describe illness, injury, or symptom requiring treatment **3B. Was patient's treatment due to a work-related accident or condition?** ❑ Yes ❑ No

3C. COMPLETE FOR CARE RELATED TO ACCIDENTAL INJURIES

Date of accident _____ Location: ❑ At home ❑ Auto ❑ Other

Time of accident _____ *If accident was caused by someone else, attach a statement describing the accident.*

4. CHARGES – USE A SEPARATE LINE TO LIST EACH TYPE OF SERVICE OR PROVIDER AND ATTACH ITEMIZED BILLS FOR ALL SERVICES.

4A. Name and address of provider making charge:	**4B.Type of provider**	**4C.Description of service**	**4D.Dates of service or purchase**	**4E.Charges**

5. PAYEE – SELECT ONE OF THE FOLLOWING PAYMENTS OPTIONS:

5A. ❑ MAKE PAYMENT TO SUBSCRIBER; PROVIDER HAS BEEN PAID.

1. Currency — Do you want the check issued in the currency reflected on the itemized bill(s) or in U.S. dollars? ❑ Currency on itemized bill(s) ❑ U.S. dollars

   NOTE: If you select reimbursement in the form of a U.S. dollar check, your payment will be sent to your domicile if you are an internationally based employee of United Airlines.

2. Payment Method — Do you want to receive payment via a check or bank wire? ❑ Check - provide telephone number:_____

   ❑ Bank Wire - provide the following: Subscriber name as it appears on bank account:_____

   Bank Name:_____ Bank's physical address:_____

   Account Number:_____ ABA Number:_____

   International Bank Account (IBAN)*:_____ Bank Identifier Code (BIC/SWIFT)*:_____

   *Required for bank wires to European Union countries.

5B. ❑ MAKE PAYMENT TO PROVIDER (HOSPITAL, DOCTOR). Please complete and sign.

Authorization for Assignment of Benefits

I, the undersigned, authorize and request Blue Cross and Blue Shield to make payment for benefits due herein to:

Name of provider _____ Signature of subscriber or spouse _____ Date _____

6. SIGNATURE – I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service that participated in any way in the patient's care to release to the subscriber's Blue Cross and Blue Shield Plan and its business associates in any country any medical or other personal information that they deem necessary to provide service or adjudicate this claim, recognizing that applicable law concerning personal information may differ among countries. Authorization is also given to the subscriber's Blue Cross and Blue Shield Plan and its business associates in any country to collect, use or release any medical or other personal information that they deem necessary to provide service or adjudicate a claim.

Signature of subscriber or patient _____ Date _____

GENERAL INFORMATION

The BlueCard Worldwide International Claim Form is to be used to submit institutional and professional claims for benefits for covered services received outside the United States, Puerto Rico, Jamaica and the U.S. Virgin Islands. For filing instructions for other claim types (e.g., dental, prescription drugs, etc.) contact your Blue Cross and Blue Shield Plan.

The International Claim Form must be completed for each patient in full and accompanied by fully itemized bills. It is not necessary for you to provide an English translation or convert currency.

Since the claim cannot be returned, please be sure to keep photocopies of all bills and supporting documentation for your personal records.

INTERNATIONAL CLAIM FORM INSTRUCTIONS

Please complete all items on the claim form. If the information requested does not apply to the patient, indicate N/A (Not Applicable). Special care should be taken when completing the following items:

2. OTHER HEALTH INSURANCE

If the patient holds other insurance coverage, please complete items A through K as completely as possible. It is especially important to indicate the name and address of the other insurance company and the policy or identification number of that coverage, as well as the name and birth date of the person who holds that policy.

In addition, if the patient is someone other than the subscriber and has received benefits from any other health insurance plan held by reason of law or employment, the Explanation of Benefits Form furnished by other carrier pertaining to these charges must be included with the claim. A clear photocopy of the other carrier's Explanation of Benefits Form is acceptable in place of the original document.

4. CHARGES

Please list here the bills that are being included on this claim. Although itemized bills must also be submitted, your listing will enable us to process the claim more quickly and accurately. If additional space is needed for listing charges, please use a separate sheet of paper to list the following information.

4A. Name and Address of provider - as indicated on the bill. Multiple bills from the same provider may be included on the same line as they are for the same type of service.
4B. Type of provider - for example: hospital, nurse, physician, clinic, physical therapist, etc.
4C. Description of service - for example: hospital admission, office visit, x-ray, laboratory test, surgery, etc.
4D. Date of service or purchase - inclusive dates may be indicated for bills containing multiple dates of service.
4E. Charge - bills must be itemized to show a separate charge for each service. If the bill has already been paid, please indicate the date it was paid.

ITEMIZED BILL INFORMATION

Each provider's original itemized bill must be attached and must contain:
– The letterhead indicating the name and address of the person or organization providing the service
– The full name of the patient receiving the service
– The date of each service
– A description of each service
– The charge for each service

This completed claim form, together with itemized bills and supporting documentation, should be submitted to:

BlueCard Worldwide Service Center
P.O. Box 72017
Richmond, VA 23255-2017 USA

Only UPS/FEDEX should be sent to this address:
BlueCard Worldwide Service Center
Attn: Healthcare Administration
2805 North Parham Road
Richmond, VA 23294, USA

5. PAYEE

5A. Make payment to subscriber, designation of currency and payment method

1. Indicate whether you want to be paid in the currency reflected on the bill(s) or in U.S. dollars and if you want to receive payment via check or bank wire. For foreign currency payments by check, please be aware of the following: to receive pament at your home address via UPS, you must include your telephone number. If a telephone number is not included with your home mailing address, your check will be sent regular mail. If you do not include a home mailing address, payment will be sent to your company domicile. If you select reimbursement in the form of a U.S. dollar check, your payment will be sent to your domicile if you are an internationally based employee of United Airlines. Please note that not all forms of currency may be available for payment. In the event that you select payment in a currency that is not available, you will be paid in U.S. dollars. Banks will typically charge a flat fee or percentage-based fee to receive a wire. You may want to investigate fees charged by your bank prior to requesting a wire since you will be responsible for any such fees.

2. You must include the following information on this form:
   - your full legal name (initials are not acceptable)
   - your physical address (payments cannot be mailed to a P.O. box)
   - wire payments must include the bank's name and physical address (P.O. box is not acceptable), your account number, bank's ABA number (a nine digit routing number that identifies a specific financial institution), and a copy of a voided check or deposit slip so that bank information can be verified.
     For checks to be sent by express mail, you must provide a current telephone number.

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5B. Authorization for assignment of benefits – complete item 5B if you prefer that benefits be paid directly to the provider of service.

6. SIGNATURE

The International Claim Form must be signed and dated by the subscriber, spouse, or the patient.