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

Insurance Carrier:
Name of Group:
Policy/ Certificate Number:

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

Instructions:

1. This form is to be used when filing a claim for reimbursement of Medical Expenses and **must** be completed by the Insured in full.
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.

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 Effective Date _____/_____/_____ Coverage Termination Date _____/_____/_____

ID Number: _____ E-Mail Address: _____

1.) Name of Insured: _____ Date of Birth ____/____/____ Sex: ___Male ___ Female

2.) Name of Claimant: _____ Date of Birth ____/____/____ Sex: ___Male ___ Female

3.) Current Residence Address: _____

Date of Arrival in U.S.: _____/_____/_____ Daytime Phone Number: (_____)_____

4.) Permanent Address (In Home Country): _____

Date scheduled to return to Home Country: _____/_____/_____

5.) If Injury, provide details, i.e., how when and where injury occurred:_____
_____

6.) If Illness, advise when and where symptoms first occurred and nature of illness:_____

_____

7.) Name and address of Consulting or Treating Physicians:_____
_____

8.) Have you ever been treated for this Illness before? Yes___ No___ If Yes, when?_____

9.) Provide Name and Address of your Regular Physician in your Home Country: _____
_____

10.) Please advise names of any prescription medications you are presently taking: _____
_____

11.) Indicate other 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.

_____ _____

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

Seven Corners, Inc.
303 Congressional Blvd.
Carmel, IN 46032 USA
800-690-6295 or 317-818-2808 Fax: 317-815-5984
Email: assist@sevencorners.com
Visit us on the web at www.sevencorners.com

SEVEN CORNERS
Specialty Insurance and Benefit Management

Correspondence/Payment Instructions

Insured: Patient:	ID #: e-mail address:
Correspondence to US: □ Yes □ No Address in the US:	Phone # in the US:
Correspondence to Out of the US: □Yes □ No Address outside the US:	Phone # out of the US:

Payments to be sent to:

Address in US: □ Yes □ No
Address out of the US: □ Yes □ No
Bank account in the US*/Overseas**: □ Yes □ No *(If yes, provide Banking Information)*

Bank's name: _____
Bank's Address: _____ City: _____ State: _____
Zip Code: _____ Phone: _____

Name on Account (exactly as it appears on your bank statements): _____
Account Number: _____
Type of account: _____ Bank currency for this account: _____
Bank Routing Number / Sort Code: _____
Iban Number (**required** for wire transfers): _____

* 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, Inc. to mail any correspondence and/or payments to the above listed address. I further agree to release Seven Corners, Inc. of any and liability in the event of lost or stolen correspondence/payments and currency exchange risk. Seven Corners, Inc. is not responsible for rejected or incomplete bank transfers, due to invalid account information provided.

_____ _____
Signature of Insured Date

Optional for Insured's Convenience:

I further authorize Seven Corners, Inc. 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: _____. I certify that this email address is restricted to the insureds under this policy and that I will be responsible for assuring that this information is not accessed by or shared with parties who are not authorized to review the information.

_____ _____
Signature of Insured Date