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

FRAUD STATEMENTS

General: 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.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Maryland, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Delaware, Idaho, Indiana: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another person files a 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 the person to criminal and civil penalties.

Minnesota; A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in section 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

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.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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.

Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: 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.

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