Global
CLAIMS ADMINISTRATION

Member of the Global Group of Companies
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ACCIDENT & SICKNESS INSURANCE CLAIM FORM

GROUP:_____ **POLICY NUMBER:**_____ **DATE:**_____

Name_____ Gender: (circle one) **Male or Female** Date of Birth_____

Current Home Address_____
Number and Street City State Zip Code Phone Number

Name of Dependent_____ Date of Birth_____

1. Date of injury or beginning of sickness_____ When was physician first consulted? _____
2. Work-related injury? ❑ Yes ❑ No Injury due to motor vehicle accident? ❑ Yes ❑ No Active-Duty Military? ❑ Yes ❑ No
3. If injury, describe how and where accident occurred
   _____
   _____
4. Nature of injury or sickness _____
5. List all medications prescribed for this injury/sickness_____
6. Did injury occur during practice or play of sports? ❑ Yes ❑ No
   If yes, please check one of the following: ❑ Collegiate Varsity Team ❑ Collegiate Intramural/Club Team ❑ Recreational Sports Team
   ❑ High School Varsity/Junior Varsity Team ❑ High School Intramural/Club Team ❑ Unofficial Sports Game
   Name of Sport _____ Signature of Athletic Trainer (If applicable) _____
7. Have you suffered same or similar condition before? ❑ Yes ❑ No
8. If you were previously seen please list dates treated and name and address of doctors who treated you:_____
   _____
   _____
   _____

Do you have other insurances: ***Group***: ❑ Yes ❑ No ***Individual***:❑ Yes ❑ No ***Automobile***:❑ Yes ❑ No ***Medical***: ❑ Yes ❑ No

If yes, who is the Holder of Policy? ❑ Self ❑ Parent ❑ Spouse Give name of Company_____

If covered under Parent's/Spouse's Insurance or if privately insured, please include the following information:

Policy #:_____ Group #:_____ Phone # of Insurance Company:_____

Parent's/Spouse's Name (Holder of Policy)_____ Social Security #_____

Employer's Name and Address_____

ASSIGNMENT OF BENEFITS:

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN, AND OTHERS), UNLESS PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

IMPORTANT: THIS FORM MUST BE COMPLETED AND RETURNED TO THE COMPANY WITHIN 90 DAYS FROM THE DATE OF TREATMENT ACCOMPANIED BY ALL BILLS INCURRED TO THAT DATE. PLEASE ATTACH ITEMIZED BILLS.

AUTHORIZATION: I hereby authorize Global Claims Administration, or its representative, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, x-rays, and any other data covering this and/or previous confinements and/or disabilities. By signing this form, you agree that all answers are honest and can be verified if any additional information is requested.
A photostatic copy of this authorization shall be deemed as effective and valid as the original.

SIGNATURE OF PARENT (If claimant is a minor) OR CLAIMANT_____ **DATE**_____

IMPORTANT NOTICE

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION

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 or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of 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 Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW: 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

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.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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.

DELAWARE: 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.

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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KANSAS: A “fraudulent insurance act” means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

KENTUCKY:
Application: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
Claim Form: 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.

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

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

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 RSA 638:20.

NEW JERSEY:
Application: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
Claim Form: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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.

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.

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: 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:
IMPORTANT NOTE: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

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

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

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

NEW YORK FRAUD WARNING: 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.

HOW TO FILE A CLAIM

Please follow these instructions:

- Complete front of claim form, in full;
- Sign Medical Authorization and Authorization to Pay Benefits on front of claim form;
- Mail to Administrator with itemized bills, showing diagnosis, and Explanation of Benefits from your primary insurance carrier for each bill (if applicable)

All itemized bills must include:

1. Patient's Name.
2. Patient's Address.
3. Diagnosis (ICD10).
4. Date of Service.
5. Description of Service (CPT Coding).
6. Medical Provider's Name, Address, Telephone Number, and Federal Tax ID Number.
7. Office Notes from referring/ordering physician if related to COVID19.
8. Copy of your valid passport.

- A completed claim form must be submitted for each injury or sickness a student sustains.

Keep copies of all claims forms, bills, and correspondence for your own records.
In order for benefits to be paid, claim forms must be filed within 90 days from the date of injury or sickness.