ACCIDENT 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: **Nationwide Life Insurance Company**
Name of Group**:** **Liaison Student**
Policy Number**:**

ID#_____
You must supply your ID #

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, for each diagnosis.
2. Fully itemized bills including Claimant's Name, Nature of Illness/Injury, must be included with this claim form, if available.
3. **Copies of your passport and either your I-20 or DS-2019 visa or form I-94 MUST be submitted with the this claim form.**
4. This form must be signed and dated in all applicable sections. In some cases, two signatures are required (minor dependent).
5. This form and all attached bills must be submitted to the address indicated above.

The furnishing of this form, or its acceptance 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 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.

Coverage Effective Date _____/_____/____ Coverage Termination Date _____/_____/_____ E-Mail Address: _____

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

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

3.) Current Residence Address: _____
Daytime Phone Number: (_____)_____

4.) Permanent Address (In Home Country): _____
Date scheduled to return to Home Country: _____/_____/_____

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

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

7.) Did you treat at a student health center (yes/no)? ____ If yes, you must provide document of the date(s) of treatment for this condition with this form.

8.) Name and address of Consulting Physicians:_____
_____

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

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

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

12.) Indicate other Health 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 or benefit plan administrator furnish to the Claims Administrator named above or its representatives, 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 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 administrators to provide the Claims Administrator 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.

In addition, I hereby certify that the above information is true and correct to the best of my knowledge and belief. I have reviewed and understand the Fraud Notices on page 2 of this document.

__X__(PATIENT)_____ __X_____
Signature of Claimant or Parent, If Claimant is a Minor Date

Copies of your passport and either your I-20 or DS-2019 visa, or form I-94 MUST be submitted with the this claim form.

State Fraud Notices—
For Use On Applications and Claims Forms

(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.

(California) For your protection California law requires the following to appear on this form. 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.

(Missouri) An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

(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.

(Puerto Rico) Any person who, knowingly and with the intent to defraud, presents false information inan insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

(Washington) Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."

(All Other States) 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/or civil penalties.