

CLAIM FORM

Please complete Parts 1, 2, 3, 4 & 5 if applicable.

Mail all claim forms and all original itemized bills for services and supplies to:

Azimuth Risk Solutions, LLC

website: www.azimuthrisk.co

PO Box 627

E-mail: service@azimuthrisk.com

Indianapolis, IN 46206

Phone: 317-644-6291 / 888-201-8850

Fax: 317-423-9620 / 888-201-8851

For any additional questions or concerns please contact us via e-mail, fax or phone.

Part 1: Please complete claim form below. All communications of this claim will be sent to the address below.

Is this claim related to (please check one)

Accident Related Injury Dental Accident Illness/Injury

Claimant/Patient Name: _____ Date of Birth: MM/DD/YYYY

Male
 Female

Policy Holder's Name: _____ Date of Birth: MM/DD/YYYY

Male
 Female

Complete Mailing Address for all correspondence:

Address, City, State: _____ Postal Code: _____

Country: _____ Email: _____

Telephone: _____ Work Telephone: _____

Destination Country(ies): _____ Identification Number: _____

Citizenship of Claimant: _____ Home Country: _____

Full Time Student: Yes No

If Yes, please provide the name and address of the school:

Name: _____

Address, City, State, Postal Code: _____

Is this a continuing claim:

Yes – If Yes, please provide original dates of the initial claim form sent:
 No

Part 2: If covered by another insurance plan please complete below.

Do you have additional insurance: Yes No

Name of Primary Insured of other insurance company: _____ Date of Birth: MM/DD/YYYY

Please provide name of other insurance company:

Name: _____

Mailing address of other insurance company: _____

Address, City, State: Postal Code: _____

Country: _____

Policy Number of insurance plan: _____

Group Number of insurance plan: _____

(Continued on back page)

This form must be submitted within 90 days of hospital/doctors visit. Failure to do so may result in denial of eligible expenses.

Part 3: Please fill out all applicable questions below, more information may be requested.
(If you need additional space, please attach a separate sheet.)

How did this condition/illness begin? Please describe all symptoms.

When did the first symptom of the illness/condition begin? (MM/DD/YYYY)

Have you ever been treated for this illness/condition before? Yes No

List all the names and address of the providers you have seen for this illness/condition:

Name: _____
Address, City, State: _____ Postal Code: _____
Country: _____ Telephone: _____

Name: _____
Address, City, State: _____ Postal Code: _____
Country: _____ Telephone: _____

Is this illness/condition the result of an accident? Yes No

Is this illness/condition related to a work accident? Yes No
If yes, have you applied for Workers Compensation? Yes No

Did this illness/condition involve a motor vehicle? Yes No
If yes, please provide names of all parties involved, including insurance carriers and policy numbers including dates of accident:

Name(s) _____
Insurance Carrier(s) _____
Policy # _____
Date(s) _____

Was a policy report filed? Yes No (If yes, Name and Number of Police Department, and number of report:)

Part 4: Please complete only if treatments occurred outside the US.

Country which treatment occurred in:	Condition(s)/Diagnosis	Physician/Hospital/Clinic/Health Care Provider Name(s), Address & Phone	Date(s) of Treatment	Total Charge — paid/bill?	Type of Currency — paid/bill?

Part 5: Authorization, please complete for all claim forms.

I verify all information contained in this form is true, correct and complete to the best of my knowledge.

The undersigned authorizes any doctor, medical practitioner, hospital, clinic, health facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, or insurance or benefit administrator or any other entity having information as to the care, advice, treatment, diagnosis, or physical or mental condition of any family member listed on this Application to release said information to Azimuth Risk Solutions, LLC.

Notice: Any false statement, concealment or fraud shall render this insurance null and void and claims hereunder shall be forfeited.
Authorization: I authorize payment of medical benefits to the doctor or other supplier of services submitting the **attached bills**.

Print Name of Primary Insured _____ Date (MM/DD/YYYY) _____

Signature of Insured or Guardian _____ Date (MM/DD/YYYY) _____

This form must be submitted within 90 days of hospital/doctors visit. Failure to do so may result in denial of eligible expenses.

AUTHORIZATION:

I AUTHORIZE any insurance company, physician, hospital, and other health care providers, any travel organization or agency, airline carrier, rental agency, hotel, motel, or similar entity providing lodging on a rental/lease basis or any other person who may have knowledge regarding this claim, to release any information requested regarding this claim and the loss reported.

I UNDERSTAND that The Beacon Series Travel Medical Plan, administered by Azimuth Risk Solutions, LLC., does not cover losses caused by injury or sickness to the extent that they are eligible under this travel medical insurance policy wording, now therefore, as a condition for my receipt of immediate benefits under the Beacon Series plan, for claims in connection with injury or sickness beginning on the date shown above, I irrevocably agreed to: (a) assign all benefits payable from my primary insurer to Azimuth Risk Solutions, LLC; (b) promptly reimburse Azimuth Risk Solutions, LLC if and when I receive payment(s) from my primary insurance; (c) allow Azimuth Risk Solutions, LLC to file a claim with my primary insurer to receive direct reimbursement; and (d) when requested by Azimuth Risk Solutions, LLC, to furnish Azimuth Risk Solutions, LLC with copies of my primary insurer's schedule of benefits.

I UNDERSTAND the information obtained by use of the authorization, will be used by Azimuth Risk Solutions, LLC to determine eligibility for benefits under this plan. Any information obtained will not be released by Azimuth Risk Solutions, LLC to any person or organization

EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I further authorize.

I KNOW that I may request to receive a copy of the Authorization. I AGREE that a photographic copy of this authorization is as valid as the original. I AGREE that this Authorization shall be valid for two and one half years from the date shown below. I UNDERSTAND that it is illegal to knowingly file a false or fraudulent claim or to knowingly help someone else file one. I have read and understand the Fraud Notices on page 4 of this document.

Signature: _____

Date: _____

Mailing Instructions:

Send this form and any accompanying documentation to:

Azimuth Risk Solutions, LLC

PO Box 627

Indianapolis, IN 46206

Phone: 317-644-6291/888-201-8850

Fax: 317-423-9620/888-201-8851

Authorization for Reimbursement Form

Please Fax, Email, or Mail all COMPLETED forms for authorization of payment to:

Azimuth Risk Solutions, LLC
Attn: Claims Dept.
P.O. Box 627
Indianapolis, IN 46206

Website: www.azimuthrisk.com
E-mail: service@azimuthrisk.com
Phone: 317-644-6291/888-201-8850
Fax: 317-423-9620/888-201-8851

Please complete the form below to authorize payment.

I understand this consent form is to authorize payment of my medical benefits to the undersigned person(s) below. I will be responsible for paying all insurance co-pay and deductibles and unpaid balances by my insurance carrier to the Provider.

Claimant/Patient Name/Insured Name:		Date of Service of your claim:	
Date of Birth: M/D/Y	<input type="checkbox"/> Male <input type="checkbox"/> Female	Name of Provider where services were incurred:	
Complete Mailing Address:		City, State:	Postal Code:
Email of Insured:		Telephone Number of Insured:	
Destination Country(ies):			
Identification Number/Group Number:	Citizenship of Claimant:	Home Country:	
Authorized Party to be reimbursed (last name, first name):			
Reimbursement to be mailed to this Street Address:		City State:	Zip:
Insured Signature (consent for payment for all services to be reimbursed to the name provided below):			Date:

ACCIDENT QUESTIONNAIRE

INSURED INFORMATION:

ID Number:	Name Primary Insured:		
Name of Claimant/Patient:	Date of Birth of Patient: MM/DD/YYYY		
Work Phone:	Fax #:	Home Tel #:	
Email Address:	Social Security # of Claimant/Patient:		
Address:	City:	State:	Zip Code:

DESCRIPTION OF INJURY/ILLNESS:

Was the injury or illness: Auto/Motorcycle Work Related Other Accident

Date of accident/illness: MM/DD/YYYY

Location of accident/illness

Describe the injury or illness and how it happened:

Is this illness/condition related to a work accident? Yes No

If yes, have you applied for workers compensation? Please provide claim number.

Did this illness/condition involve a motor vehicle? Yes No

If yes, please provide names of all parties involved, including insurance carriers and policy/claim numbers including the dates of accident:

Name(s)

Insurance Carrier(s)

Policy/Claim #(s)

Date(s)

Was a police report filed? Yes No

If yes, Name and Number of Police Department, and number of report:

Authorization For Release of Medical Information — To be Completed by Patient

In order to process a claim for benefits, I authorize any physician, hospital, or other Medical Provider to release to Azimuth Risk Solutions, or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed two and one-half years from the date signed.

I understand I have a right to receive a copy of this authorization.

Signature:

Date:

(Signature of Person Suffering Illness or Injury or legally authorized representative)

This form must be submitted within 90 days of hospital/doctors visit. Failure to do so may result in denial of eligible expenses.