

# International Medical & Accident Insurance

## Academic High School Program, Private School Program, Short Term Program

Provided by:  
Capistrano Insurance Services, Inc.



Capistrano Insurance Services, Inc.  
Tel: 877.203.7252 or 909.472.3300  
Fax: 909.472.3310  
email: info@capistrano-ins.com  
www.capistrano-ins.com

### COVERAGE PROVIDED THROUGH THE INTERNATIONAL ACCIDENT & TRAVEL SICKNESS PROGRAM

International Accident & Sickness Medical Coverage is available 24 hours a day when you travel outside your country of residence or country of permanent assignment.

The following benefits are available.

#### ACCIDENT & SICKNESS MEDICAL EXPENSE

Provides coverage for reimbursement of covered medical expenses for in-hospital and out-of-hospital treatment.

#### ACCIDENT DEATH & DISMEMBERMENT

Provides coverage of death and dismemberment, including loss of sight or hearing, as the result of a covered accident.

#### EMERGENCY MEDICAL EVACUATION

Provides Coverage for transportation to the nearest medical facility qualified to treat the covered emergency

#### REPATRIATION

Provides coverage for returning the Insured's remains to family members in the event of death.

PLEASE REFER TO THE FOLLOWING DESCRIPTION OF BENEFITS AND PLAN OPERATIONS FOR FURTHER DETAILS



#### For Questions of:

Eligibility

Benefits

Claims Filing

Please contact  
Azimuth Risk Solutions at  
1-888-201-8850

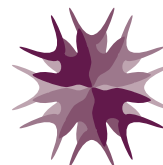


#### Council for Educational Travel

**High School Program** Tel: 888.238.8721 Fax: 616.365.9941

**Private School Program** Tel: 888.725.7747 Fax: 574-264-9711

[www.cetusa.org](http://www.cetusa.org)



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**The Beacon Series Group Travel Medical Plan Schedule of Benefits**

Maximum Limits	\$1,000,000
Deductibles	\$0 per Coverage Period
Coinsurance (Subject to the Deductible)	The plan pays 80% of next \$5,000 of Eligible Expenses, then 100% to the Overall Maximum Limit for claims incurred in the US & Canada. (The Coinsurance is waived if incurred in the US and within the PPO). Plan pays 100% for claims incurred outside US & Canada
Pre-Certification Penalty	50%
Hospital Indemnity	\$150 per night; Inpatient Hospitalization (Outside the US and Canada)
Hospital Room and Board	Average Semi-private room rate
Intensive Care Unit	Usual, Reasonable, and Customary to selected Policy Maximum Limit
Local Ambulance	Usual, Reasonable, and Customary charges, when covered illness or injury results in Hospitalization is inpatient
Physical Therapy	\$60 Maximum Limit per visit. Maximum 15 visits
Sudden Onset of Pre-existing Condition	\$20,000 Maximum Limit for Eligible Medical Expenses, Including Emergency Medical Evacuation (US citizens only.) \$1,000 Maximum Limit for Eligible Medical Expenses (all others)
All Other Medical Expenses	Usual, Reasonable and Customary charges
Dental (Injury as result of Accident) Only available for Policies purchased for 90 days or more	\$250 Maximum Limit per Coverage Period
Emergency Medical Evacuation	\$150,000 Maximum Limit
Emergency Reunion	\$15,000 Limit per Coverage Period
Return of Mortal Remains	\$30,000 Limit per Coverage Period
Return of Minor Children	\$5,000 Limit per Coverage Period
Quick Trip Home Country Coverage	14 days cumulative Home Country Coverage (as defined in Policy). Subject to a Minimum 3 month purchase.
Home Country Coverage (End of Trip)	Free 15 days with a 6 month purchase, or Free 30 days with a 12 month purchase per Coverage Period
Lost Checked Luggage	\$250 per Coverage Period (not subject to Deductible or Coinsurance). As defined in the Policy
Accidental Death and Dismemberment (AD&D)	\$30,000 for Insured or Insured spouse and \$6,000 for Dependent Child(ren)
Common Carrier Accidental Death and Dismemberment	\$50,000 per Member (age 18 and over) \$30,000 per Member (under age 18)
Terrorism	\$50,000 Maximum Limit, Medical expenses only
Trip Delay/Missed Connection	Maximum Limit of \$100 a day after a minimum of 12 hour delay period. As defined in the policy
Third Party Liability-Personal Liability	\$500 per Coverage Period
Third Party Liability-Damage to Property	\$150,000 Maximum Limit personal liability and damage to property

**The Aggregate Limit for the Personal Liability Coverage per Participating Member equals the above Limit.**

With regard to the foregoing Schedule of Benefits/Limits, the references to "continuous coverage" mean continuous unbroken coverage under the Beacon/Axis Series Group Insurance Trust (Anguilla). The applicable benefits described will become first available to the Participating Member only at the end of the continuous Coverage Period so specified.



Insured Name:  
**Council for Educational Travel USA**  
**High School / Short Term / Private School Program Participant**

Policy Identification #: **BG00003**

Please visit our website at [www.azimuthrisk.com](http://www.azimuthrisk.com) or email us at [service@azimuthrisk.com](mailto:service@azimuthrisk.com) with any inquiries.



Pre-certification is required for all hospitalizations, surgeries, emergency evacuations, emergency reunions, repatriation of remains, quick trip home, trip delay / missed connection, computerized tomography (CAT Scan) and magnetic resonance imaging (MRI).

Emergency hospital admissions must be reported within 48 hours of admission. Providers, you, or a family member must notify Azimuth Risk Solution. Failure to comply may result in a reduction of benefits.

For calls regarding pre-certifications, eligibility, benefits, claims, or general questions please call Azimuth at (888) 201-8850 in the U.S or (317)644-6291 outside the U.S (We do accept collect calls) or visit our website [www.azimuthrisk.com](http://www.azimuthrisk.com). Claims must be filed within 90 days from date of service.

PLEASE MAIL ALL CLAIMS, CLAIM FORMS AND ITEMIZED BILLS TO:  
 Azimuth Risk Solution, LLC.  
 Attn: Claims Department  
 PO Box 627  
 Indianapolis, IN 46206



POSSESSION OF THIS CARD DOES NOT GUARANTEE COVERAGE.

**Insurance Card**  
 Please detach and  
 keep with you at all times.

## How to find an In-Network Provider in your area

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### Online instructions for locating a provider in your area:

Step 1: Visit [www.multiplan.com](http://www.multiplan.com)

Step 2: Click on "Search for a Doctor or Facility" box

Step 3: In the section titled Front of Card choose PHCS and click Continue

Step 4: From this point forward follow instructions to enter your search criteria and await results

Telephone instructions for locating a provider in your area:

If you do not have access to the internet you may contact **1-888-201-8850** toll free (inside the U.S.) or **1-317-644-6291** (outside the U.S.) for assistance in locating a provider in your area.

## How to Proceed in the Event of a Claim

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1. If your medical condition is an emergency, seek medical care wherever appropriate. **Remember to contact Azimuth by, phone, fax or email within 48 hours of hospital admission or as soon as possible.**

**Azimuth Risk Solutions**  
**(888) 201-8850 (inside the U.S.)**  
**(317) 644-6291 (outside the U.S.) We accept collect calls**  
**Email: [service@azimuthrisk.com](mailto:service@azimuthrisk.com)**

2. If your medical condition is of a non-emergency nature and the first time you have sought care for the condition, you are welcome to seek medical care wherever you choose, however it is advisable that you

search for providers via [www.multiplan.com](http://www.multiplan.com) where you can find over 450,000 facilities and other health care professionals. This is particularly useful for two reasons: First, the likelihood that a contracted provider will accept direct claims settlement (after your deductible is satisfied) with Azimuth, rather than requiring that you pay eligible expenses immediately and would eliminate the need to personally complete the claim form information. Secondly, claims are negotiated at a reduced rate, so even if you pay the deductible then submit the claim to Azimuth, we will submit the charge for re-pricing and you will receive an Explanation of Benefits which will reflect the reduced amount applied to your deductible. You would then be able to contact your health care provider to request a refund of the reduced percentage amount. Remember it is required that you contact Azimuth by phone, fax or email before any scheduled surgeries, or diagnostic procedures as well as within 90 days of pregnancy. (Meridian Series only)

3. After receiving medical care, you collect itemized receipts for paid expenses
4. Print the Azimuth claim form and complete. Please note that all information on this form should be completed. If a question does not apply to you, please insert DNA, or check "No" if appropriate. Review for full completion and then return to the address indicated in Item #5. **There is a 90 day time limit for filing claims. Please use the Azimuth Risk Solutions claim form attached to this brochure and send to the address provided. Failure to submit the proper completed claim form may result in denial of eligible expenses.**
5. Mail the completed Azimuth claim form along with itemized receipts to:

**Azimuth Risk Solutions, LLC**  
**Attn: Claims Department**  
**PO Box 627**  
**Indianapolis, IN 46206**

6. Wait approximately 10 business days, and you will receive a prompt reimbursement for eligible medical expenses in the mail. \*Note: there are occasions when further medical information may be requested by Azimuth in order to fully process your claim. Azimuth will make every effort to process these claims in a timely manner; however, delays sometimes occur as a result of waiting for required information to arrive.

## Exclusions

- **Exclusions** - All Charges, costs, expenses and/or (collectively "Charges") incurred by the Participating Member and directly or indirectly relating to or arising from or in connection with any of the following acts, omissions, events, condition, charges, consequences, claims, Treatment (including diagnoses, consultations, tests, examinations and evaluations related thereto), services and/or supplies are expressly excluded from coverage under this insurance, and the Scheme Administrator shall provide no benefits and shall have no liability therefore:
- **War; Military Action; Terrorism** – The Scheme Administrator shall not be liable for and will not provide coverage or benefits for any claim or Charges, Illness, Injury or other consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to or arising in connection with any of the following acts or events (collectively, "Occurrences"):
  - war, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not), or civil war;
  - mutiny, riot, strike, military or popular uprising, insurrection, rebellion, revolution, military or usurped power;
  - any act of any person acting on behalf of or in connection with any organization with activities directed towards the overthrow by force of the Government de jure or de facto or to the influencing of it by violence of any type; martial law or state of siege or any events or causes which determine the proclamation or maintenance of martial law or state of siege; or
  - Terrorism: For the purpose of this insurance, an "Act of Terrorism" means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organizations(s) or government(s) committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear. All other Terms, clauses and conditions remain unchanged.
- Any claim, Charges, Illness, Injury or other consequence happening or arising during the existence of abnormal conditions (whether physical or otherwise), whether or not directly or indirectly, proximately or remotely occasioned by, or contributed to by, traceable to, or arising in connection with, any of the said Occurrences shall be deemed and considered to be consequences for which the Scheme Administrator shall not be liable under the Evidence of Insurance, except to the extent that the Participating Member shall prove that such claim, Charges, Illness, Injury or other consequence happened independently of the existence of such abnormal conditions and/or Occurrences; and
- **Pre-existing Conditions** – Charges resulting directly or indirectly from or relating to any Pre-existing Condition are excluded from coverage under this insurance unless the Insured Person excepts charges resulting from the Sudden Onset of a Pre-Existing Condition, thereafter such Charges are limited in coverage as provided in **Section 21**, Schedule of Benefits/Limits, above; and
- **Maternity** – Charges related Pregnancy and;
  - Routine pre-natal care, Child birth, and post-natal care, and
  - False Labor, edema, prolonged labor, prescribed rest during the period of Pregnancy, including Newborn Care
- **Charges incurred for Surgeries or Treatment or supplies which are:**
  - Investigational, Experimental, or for Research Purposes, and/or
  - Charges for any Child under the age of fourteen (14) days, and
  - Any Treatment for or related to any congenital condition, and
  - Any charges which are not incurred by a member during his/her Evidence of Insurance Period
  - Charges which are not submitted within the timely filing limits
  - Treatment, services or supplies which are not medically necessary related to genetic medicine or genetic testing, including without limitation amniocentesis, genetic screening, risk assessment, prevention and/or to determine pre-disposition, genetic counseling, and/or gene therapy; and
  - Any immunizations and routine physical exams.
- Charges incurred while confined primarily to receive Custodial Care, Educational or Rehabilitative Care; and
- **Charges incurred for any Surgery, Treatment or supplies relating to, arising from or in connection with, for, or as a result of:**
  - Weight modification or any Inpatient, Outpatient, Surgical or other Treatment of obesity (including without limitation morbid obesity), including without limitation wiring of the teeth and all forms of bariatric Surgery by whatever name called, or reversal thereof, including without limitation intestinal bypass, gastric bypass, gastric banding, vertical banded gastroplasty, biliopancreatic diversion, duodenal switch, or stomach reduction or stapling; and/or
  - Modification of the physical body in order to change or improve or attempt to change or improve the physical appearance or psychological, mental or emotional well-being of the Insured Person (such as but not limited to sex-change Surgery or Surgery relating to sexual performance or enhancement thereof); and/or
  - Cosmetic or aesthetic reasons, except for reconstructive Surgery when such Surgery is Medically Necessary and is directly related to and follows a Surgery which was covered under this insurance; and/or
  - Any Injury or Illness sustained while taking part in mountaineering activities where specialized climbing equipment, ropes or guides are normally or reasonably should have been used, Amateur Athletics, Professional Athletics, aviation (except when traveling solely as a passenger in a commercial aircraft), hang gliding and parachuting, snow skiing except for recreational downhill and/or cross country snow skiing (no cover provided whilst skiing in violation of applicable laws, rules or regulations; away from prepared and marked inbound territories; and/or against the advice of the local ski school or local authoritative body), racing of any kind including by horse, motor vehicle (of any type) or motorcycle, spelunking, and sub aqua pursuits involving an derwater breathing apparatus (except as otherwise expressly set for the in **Section 32.7** Recreational Underwater Activities). Practice or training in preparation for any excluded activity which results in Injury will be considered as activity while taking part in such activity; and/or
- Any Illness or Injury sustained while participating in any sporting, recreational or adventure activity where such activity is undertaken against the advice or direction of any local authority or any qualified instructor or contrary to the rules, recommendations and procedures of a recognized governing body for the sport or activity; and/or
- Any Illness or Injury sustained while participating in any activity where such activity is undertaken against medical advice, and/or
- Any Injury or Illness sustained as a result of being under the influence of or due wholly or partly to the effects of intoxicating liquor or drugs other than drugs taken in accordance with Treatment prescribed and directed by a Physician but not for the Treatment of Substance Abuse; and/or
- Any Injury or Illness sustained while operating a moving vehicle after consumption of intoxicating liquor or drugs other than drugs taken in accordance with Treatment prescribed and directed by a Physician. For purposes of this exclusion, "vehicle" shall include both motorized devices for which a driver or operator license is required (including watercraft and aircraft) and non-motorized bicycles and scooters for which no permit or license is required; and/or

- Any willfully self-inflicted Injury or Illness; and/or
- Any venereal disease; and/or
- Treatment by a chiropractor
- Treatment of a mental health disorder
- Treatment for acne, other acne, moles, skin tags, diseases of sebaceous glands, seborrhea, sebaceous cyst, unspecified disease of sebaceous glands, hypertrophic and atrophic conditions of skin.
- Telephone consultations or failure to keep a scheduled appointment
- Any testing for the following: **HIV**, seropositivity to the AIDS virus, AIDS related illnesses, ARC Syndrome, AIDS; and/or
- Any Illness or Injury resulting from or occurring during the commission of a violation of law by the Insured Person, including, without limitation, the engaging in an illegal occupation or act, but excluding minor traffic violations; and/or
- Any Substance Abuse; and/or
- Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy; and/or
- Orthoptics, visual therapy or visual eye training
- The feet, including without limitation: orthopedic shoes; orthopedic prescription devices to be attached or to be placed in shoes; Treatment of weak, strained, flat, unstable or unbalanced feet; metatarsalgia, bone spurs, hammertoes or bunions; and any Treatment or supplies for corns, calluses or toenails; provided, however, that claims for Treatment or supplies for the feet may be eligible for coverage under this insurance at the sole option of the company and subject to all other Terms of the insurance when related to:
  - An Injury to the foot arising from an Accident covered hereunder; or
  - An Illness for which foot surgery is Medically Necessary and determined to be the only appropriate method of Treatment; and/or
- Hair loss, including without limitation wigs, hair transplants or any drug that promises to promote hair growth, whether or not prescribed by a Physician; and/or
- Any sleep disorder; and/or
- Any exercise program, whether or not prescribed or recommended by a Physician; and/or
- Any exposure to any non-medical nuclear or atomic radiation, and/or radioactive material(s); and/or
- Any artificial or mechanical devices designed to replace human organs temporarily or permanently; and/or
- Charges incurred for any Treatment or supply that either promotes or prevents or attempts to promote or prevent conception; including but not limited to: artificial insemination; oral contraceptives, Treatment for infertility or impotency; vasectomy or reversal of vasectomy; sterilization or reversal of sterilization; and
- Charges incurred for any Treatment or supply that either promotes, enhances or corrects or attempts to promote, enhance or correct impotency or sexual dysfunction; and
- Charges incurred for Dental Treatment, except for Emergency Dental Treatment necessary to repair or replace sound natural teeth lost or damaged in an Accident covered hereunder or as necessary Treatment of sudden, unexpected pain to sound natural teeth, and subject to the limits set forth in the Schedule of Benefits/Limits;
  - For policies purchased more than 90 (ninety) days.
  - \$250 maximum Limit per Policy Period.
- Charges incurred for eyeglasses, contact lenses, hearing Aids, hearing implants and Charges for any Treatment, supply, examination or fitting related to these devices, or for eye refraction for any reason; and
- Charges incurred for eye Surgery, such as but not limited to radial keratotomy, when the primary purpose is to correct or attempt to correct nearsightedness, farsightedness, or astigmatism; and
- Charges incurred for Treatment of the temporomandibular joint; and
- Charges incurred by the Insured Person for the Treatment of his/her Newborns (or for supplies related thereto); and
- Charges incurred for any travel, meals, transportation and/or accommodations, except as otherwise expressly provided for in this insurance; and
- Any taxes, assessments, charges, fees or surcharges imposed by any governmental agency or authority:
  - Arising out of or as a result of any Treatment or supplies received by the Insured Person, or
  - Based upon the Company's election hereunder, if any, to pay benefits directly to providers, or
  - For any other reason; and
- Complementary Medicine, charges or expenses incurred for nonprescription drugs, medicines, vitamins, food extracts, or nutritional supplements; IV vitamin or herbal therapy; drugs or medicines not approved by the U.S. Food and Drug Administration or which are considered "off-label" drug use; and for drugs or medicines not prescribed by a Physician.
- **TRANSPLANTS:**
- Any organ or tissue or other transplant or related services, Treatment or supplies, except for Covered Transplants as defined herein and covered pursuant to the Terms of this insurance; and/or
- Any artificial, non-human organs, or mechanical devices designed to replace human organs temporarily or permanently; and/or
- Any efforts to keep a donor alive for a transplant procedure, whether or not the transplant procedure is a Covered Transplant; and/or
- Any transplant expenses incurred outside the Company's approved independent Managed Transplant System Network.

**For a download version of the Beacon Series CETUSA policy provided by Azimuth Risk Solutions, please refer to your student portal at [www.CETUSA.org](http://www.CETUSA.org) or contact Capistrano Insurance Services at [info@capistrano-ins.com](mailto:info@capistrano-ins.com). It is recommended that you read the policy for a detailed explanation of your benefits and exclusions.**

## EMERGENCY MEDICAL EVACUATION BENEFIT

- **EMERGENCY MEDICAL EVACUATION BENEFIT** – Subject to the Maximum Limit set forth in the Schedule of Benefits/Limits, and the other Terms of this insurance, including the Conditions and Restrictions set forth below, the Scheme Administrator will reimburse the Participating Member for the following expenses incurred by the Participating Member arising out of or in connection with an Emergency Medical Evacuation occurring while the Evidence of Insurance is in effect:
  - Emergency air transportation to a suitable airport nearest to the Hospital where the Participating Member will receive Treatment; and
  - Emergency ground transportation necessarily preceding Emergency air transportation and from the destination airport to the Hospital where the Participating Member will receive Treatment.
- **Conditions and Restrictions** - To be eligible for coverage for Emergency Medical Evacuation benefits to Participating Member must be in compliance with all Terms of this insurance. The Scheme Administrator will provide Emergency Medical Evacuation benefits only when the condition, Illness, Injury or occurrence giving rise to the Emergency Medical Evacuation is covered under the Terms of this insurance. The Scheme Administrator will provide Emergency Medical Evacuation benefits only when all of the following conditions are met:
  - Medical Necessary Treatment cannot be provided locally; and
  - Transportation by any other method would result in loss of the Participating Member's life; and
  - Emergency Medical Evacuation is recommended by the attending Physician who certifies to the matters in subparagraphs above; and
  - Emergency Medical Evacuation is agreed to by the Participating Member or a Relative of the Participating Member; and
  - Emergency Medical Evacuation is approved in advance and all arrangements are coordinated by the Scheme Administrator; and
  - The condition, Illness, Injury or occurrence giving rise to the Emergency Medical Evacuation occurred suddenly and/or spontaneously, and without: (i) advance warning, (ii) advance Treatment, diagnosis or recommendation for Treatment by a Physician, or (iii) prior manifestation of symptoms or conditions which would have caused a prudent person to seek medical attention prior to the onset of the Emergency.

The Scheme Administrator will arrange Emergency Medical Evacuation only to the nearest Hospital that is qualified to provide the Medically Necessary Treatment to prevent the Participating Member's loss of life. The Scheme Administrator will use its best efforts to arrange with independent, third-party contractors any Emergency Medical Evacuation within the least amount of time reasonably possible. The Participating Member understands and agrees that the timeliness, duration, and outcome of an Emergency Medical Evacuation can be affected by events and/or circumstances which are not within the direct control of the Scheme Administrator, including but not limited to: availability and performance of competent transportation equipment and staff; delays or restrictions on flights or other modes of transportation caused by mechanical problems, government officials, telecommunications problems, and/or geographical and weather conditions; and other acts of God. The Participating Member agrees to hold the Scheme Administrator and its agents and representatives harmless from, and agrees that the Scheme Administrator and its agents and representatives shall not be held liable for, any delays, losses, damages or other claims that arise from or are caused by the acts or omissions of such independent third-party contractors, or that arise from or are caused by any acts, omissions, events or circumstances that are not within the direct and immediate control of the Scheme Administrator and/or its authorized agents and representatives, including without limitation the event and circumstances set forth above.

# 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](http://www.azimuthrisk.co)**

**PO Box 627**

**E-mail: [service@azimuthrisk.com](mailto: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](http://www.azimuthrisk.com)**  
**E-mail: [service@azimuthrisk.com](mailto: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.

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

