Claim Filing Instructions

Medical Expenses

You received medical treatment while on a covered trip.

1. Please complete all applicable information listed on the attached claim form.
2. If you have no other insurance, submit your medical bills that include the date of service, the billed amount, the type of service, and diagnosis.
3. If you have other insurance, we need the final statement from your other insurance company listing payment or denial of your claim with them (Explanation of Benefits or "EOB").
4. Provide proof of your payment for medical treatment received (a credit card statement or if you paid cash a receipt from the medical provider showing you paid the charges).

Medical Expense Claim Form

You received medical treatment while on a covered trip.

Disclaimer: 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.

EF PROGRAM NAME: ☐ EF Educational Tours ☐ Go Ahead Tours ☐ Ultimate Break
☐ College Study Tours ☐ Gap Year ☐ Explore America

Primary Insured's Information *Traveler's Information*

1a Name of Primary Insured (The person listed first on your plan.)	**1b** Date of birth MM/DD/YYYY		
2a Companion name	**2b** Date of birth MM/DD/YYYY		
3 Preferred phone number	**4** Email address		
3 Primary Insured's mailing address	**4** City	**5** State	**6** Zip code
7 Account number (You will find this on your I.D. card.)			
8 Trip Dates (This is your coverage period) MM/DD/YYYY - MM/DD/YYYY From: To:			
9 Travel agency name EF Tours			
10a Date of departure MM/DD/YYYY	**10b** Date of return MM/DD/YYYY		
11 Preferred method of contact: ☐ Mail ☐ Email ☐ Phone			

Incident Information

12 Date of occurrence MM/DD/YYYY	**13** Date incident/accident report was filed MM/DD/YYYY
14 Medical services requires as a result of: ☐ Illness ☐ Accident ☐ Car accident ☐ other	
15 If other, please explain	
16 Treatment received at: ☐ Medical office / clinic ☐ Hospital ☐ Emergency room ☐ House call ☐ Urgent care center ☐ Dental Office ☐ other healthcare professionals ☐ Telemedicine/ telehealth	
17 Please briefly explain the medical reasons related to this claim	

18 Expenses

Name of service provider (physicians, clinic, hospital)	Date of service MM/DD/YYYY	Account or invoice No.	Amount billed	Total amount you paid
				$
				$
				$
				$

19a In the past have you received medical attention for the mentioned symptoms or illness? ☐ **Yes** ☐ **No**	**19b** If **YES**, please indicate the date you were last treated MM/DD/YYYY
19c If **YES**, please indicate the name and address of the medical facility:	

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 Seven Corners, 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.

20 Date MM/DD/YYYY	**21** Signature (Signature of Person Suffering Illness or Injury or legally authorized representative)

Physician's Statement – To Be Completed By Physician Only

Medical documentation confirming treatment while on tour can be substituted as long as it includes the information noted in fields 31, 32, and 33 below

22 Name of Doctor	**23** Office phone Number		**24** Office fax number
25 Office mailing address	**26** City	**27** State	**28** Zip code
29 Name of Patient	**30** Age		
31 Diagnosis that resulted in cancellation/interruption			
32 Date symptoms first appeared or accident occurred MM/DD/YYYY	**33** Date of first treatment for listed diagnosis MM/DD/YYYY		
34a Was patient treated by someone else? ☐ Yes ☐ No	**34b** If **YES**, by whom?		**34c** If **YES**, when? MM/DD/YYYY
35a Was patient prohibited to travel due to this illness/injury? ☐ Yes ☐ No	**35b** If **YES**, when? MM/DD/YYYY		
36 Date Completed MM/DD/YYYY	**37** Physician's signature		

Other Insurance / Authorization

38a Do you have any other travel or out-of-country medical insurance through employer, spouse's employer, retired plan or credit card? ☐ **Yes** ☐ **No**	**38b** If **YES**, please indicate name of insurance company
39 Plan number	**40** Credit card issuing bank

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 the information obtained by use of the authorization, will be used by Seven Corners to determine eligibility for benefits under this plan. Any information obtained will not be released by Seven Corners 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 3 of this document. *A Parent or Legal Guardian may sign on behalf of a minor.*

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.

41 Signature	**42** Date MM/DD/YYYY

Send this form and any accompanying documents to Seven Corners using any of the following methods:

MAIL Seven Corners, Inc. **Attn: Claims** PO Box 211379 Eagan, MN 55121 (Allow mail 7-10 days for delivery.)	FAX (+01) 317-575-2256	EMAIL tourclaims@sevencorners.com *Quickest and most preferred*

Call for help: Local **1-317-582-2658** or Toll-free **1-866-887-7148**

Disclaimer: This claim form is used for travel insurance underwritten by United States Fire Insurance Company. C&F and Crum & Forster are registered trademarks of United States Fire Insurance Company. The Crum &Forster group of companies is rated A (Excellent) by AM Best 2023.

HIPAA Authorization to Disclose PHI and Payment Authorization

To prevent any delays in claims handling and payment processing, please sign at the end of both sections of this authorization form.

HIPAA Authorization to Disclose PHI

I authorize Seven Corners, Inc. to disclose protected health information (PHI), which will include the applicable account number and date(s) of the covered benefits received, about _____ _____ (name of covered person) to Fleetcor Technologies, Inc. d/b/a Corpay to fulfill my request for Seven Corners to pay covered travelhealth benefits via Automated Clearing House Network (ACH) transfer. This authorization will expire once all applicable fund transfers have been made. I understand that:

- I can revoke (cancel) this authorization at any time by contacting Seven Corners as follows: Call 800-335-0611 (toll free) or 317-575-2652 (worldwide) or 317-818-2809 (collect). This will not affect any disclosures Seven Corners has made in reliance on this authorization before it receives my cancellation.
- Seven Corners cannot condition payment or eligibility for benefits on whether I sign this authorization. However, if I do not sign it or if I revoke it, Seven Corners may not be able to make payment via ACH transfer.
- Any PHI disclosed under this authorization may be re-disclosed by the recipient and will no longer be protected by the HIPAA Privacy Rule.

Signature: _____ Date: _____

Printed Name: _____

If you are not the covered person, and you are signing this authorization as the covered person's legal representative (parent, guardian, etc.), please describe your legal authority: _____

Payment Authorization

The* NAME *in the contact information must match exactly the name on the ACH, checking, or wire transfer account. Joint accounts require allnames.

Payment Authorization Form

- To prevent any delays in claims handling, please be sure to sign this form.
- The ***Name*** in contact information must match exactly the name on the ACH, checking, or wire transfer account.
- Joint accounts require all names.

Contact Information

Name *Account Holder(s)*	Telephone		
Email address	I authorize Seven Corners, Inc. to contact me using this email address to discuss and/or inform me of payment confirmation. ☐ **Yes** ☐ **No**		
Mailing address (P.O. Boxes are not accepted)	City	State/Province/Region	Postal Code

1 Payment Type

☐ Check (check will ship to address above)
☐ ACH/EFT: US $ Canada(CAD) $ – complete section 2
☐ International Wire Transfer – complete section 3

2 U.S. Account Information

Account type: ☐ Checking ☐ Savings	Full Bank Name:		
Bank street address	City	State/Province/Region	Postal Code
ABA routing number	Account number	SWIFT BIC	

3 International/non-U.S. Account Information - Complete for payment through bank transfer outside the U.S.

Bank's full name			
Bank street address	City	State/Province/Region	Postal Code
Account number	Routing Number (BLZ, BSB, TRNO, branch code, etc.)		
IBAN	SWIFT BIC	Preferred reimbursement currency	

REGULATORY INFORMATION

Bank phone number	Identification number
	Account type: ☐ID ☐NIT ☐RIF ☐CPF ☐CNPJ ☐RUT ☐CUIT ☐OTHER

I hereby authorize Seven Corners, Inc. (hereinafter COMPANY) to mail any payments to the above listed address and to deposit any amounts owed me for reimbursement of relevant expenses or services rendered by initiating credit entries to my account at the financial institution (hereby BANK) indicated above. Further, I authorize BANK to accept and to credit any credit entries indicated by COMPANY to my account. In the event that COMPANY erroneously deposits funds in my account (by way of example, I am not entitled to the funds or the amount of deposit Is incorrect or such funds are deposited in the wrong account), I authorize COMPANY to debit or credit my account in the amount necessary to correct the initial deposit, but in no case shall any debit exceed the amount of the initial deposit. I further agree COMPANY is not responsible for any transaction fees charged and will release Seven Corners of any liability in the event of lost or stolen payments.

Account holder signature	Date

FRAUD WARNING STATEMENT

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.

V.03.22.2024 FRAUD STATEMENT