PROOF OF LOSS

Chartis Claims, Inc. **Accident and Health Claims Department** **Gencon Claims Department** **12501 Old Columbia Pike** **Silver Spring, MD 20904** **(800) 551-0824 (Telephone)**	**UNDERWRITTEN BY:** **GROUP NAME:** **POLICY #:**	**The Ins. Company of the State of Pennsylvania** **Gencon** **GLB 9017494**

ACCIDENT AND SICKNESS CLAIM FORM / GLOBAL

INSTRUCTIONS:

1. THIS FORM IS TO BE USED WHEN FILING A CLAIM FOR REIMBURSEMENT OF MEDICAL EXPENSES
2. SECTION A MUST BE COMPLETED BY THE INSURED IN FULL.
3. ONE OF THE FOLLOWING MUST BE PROVIDED:
   - FULLY COMPLETED MEDICAL FORM BY THE ATTENDING PHYSICIAN, AND/OR
   - FULLY ITEMIZED BILLS FROM TREATMENT CENTERS SHOWING CLAIMANT'S NAME, NATURE OF ILLNESS/INJURY, DESCRIPTION AND CHARGE FOR EACH SERVICE.
4. THIS FORM MUST BE SIGNED AND DATED IN ALL APPLICABLE SECTIONS.
5. THIS FORM AND ALL ATTACHED BILLS MUST BE SUBMITTED TO THE ADDRESS INDICATED ABOVE.
6. READ, COMPLETE, AND SIGN THE AUTHORIZATION AND ASSIGNMENT OF BENEFITS SECTION ON THE FOLLOWING PAGE.

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.

SECTION A: MEMBER / CLAIMANT INFORMATION

INSURED / MEMBER NAME	ADDRESS OF INSURED / MEMBER		
CLAIMANT (PATIENT) NAME	ADDRESS OF CLAIMANT (IF DIFFERENT THAN MEMBER'S)		
DATE OF ARRIVAL IN UNITED STATES: (MO / DAY / YEAR)	PERMANENT ADDRESS (IN HOME COUNTRY):		
CLAIMANT'S RELATIONSHIP TO MEMBER ☐ SELF ☐ SPOUSE ☐ CHILD	CLAIMANT'S GENDER ☐ MALE ☐ FEMALE	CLAIMANT'S DATE OF BIRTH:	CLAIMANT SOCIAL SECURITY #:
IF CLAIMANT IS A MINOR, NAME OF GUARDIAN:	ARE YOU FLUENT IN ENGLISH? ☐ YES ☐ NO IF NO, GIVE PRIMARY LANGUAGE:		
PRIMARY DAYTIME PHONE #:	SECONDARY DAYTIME PHONE #:	EMAIL ADDRESS:	FAX NUMBER:

SECTION B: INSURANCE / PHYSICIAN INFORMATION

HAVE OTHER HEALTH INSURANCE? ☐ YES ☐ NO	IF YES, PLEASE PROVIDE THE FOLLOWING: COMPANY NAME: GROUP NAME: POLICY NUMBER:	
NAME OF CURRENT TREATING PHYSICIAN:	ADDRESS OF TREATING PHYSICIAN:	TREATING PHYSICIAN PHONE #:
NAME OF REGULAR PHYSICIAN (IN HOME COUNTRY):	ADDRESS OF REGULAR PHYSICIAN (IN HOME COUNTRY):	

SECTION C: ACCIDENT / SICKNESS DETAILS

IF ACCIDENT, PLEASE COMPLETE THE FOLLOWING:	WHEN DID THE ACCIDENT HAPPEN: (MO / DAY / YEAR)	SPECIFY TIME: ☐ AM ☐ PM
WHERE DID ACCIDENT HAPPEN (PLEASE BE SPECIFIC):	HOW DID ACCIDENT HAPPEN (PLEASE GIVE DETAILS AND SPECIFY BODY PART)	
IF SICKNESS, PLEASE COMPLETE THE FOLLOWING:	WHEN DID THE SYMPTOMS BEGIN: (MO / DAY / YEAR)	DATE FIRST TREATED: (MO / DAY / YR)
WHERE DID SYMPTOMS FIRST OCCUR:	PLEASE DESCRIBE SYMPTOMS	

WERE YOU TAKING MEDICATIONS PRIOR TO YOUR ACCIDENT OR SICKNESS? ☐ YES ☐ NO
IF YES, PLEASE COMPLETE THE BELOW:

DRUG NAME: .	PRESCRIBED FOR: .	PHYSICIAN NAME: .	DATE FIRST PRESCRIBED: .

AUTHORIZATION and ASSIGNMENT OF BENEFITS

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 INUSRANCE 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 REPRESETATIVE MAY REQUEST A COPY OF THIS AUTHORIZATION.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICE PROVIDED.	☐ YES ☐ NO

OPTIONAL LIMITED ASSIGNMENT

I HEREBY MAKE A LIMITED ASSIGNMENT TO _____ (MY "ASSIGNEE") OF THE RIGHT TO RECEIVE THE BENEFITS DUE FOR THOSE COVERED MEDICAL EXPENSES INCURRED BY ME AND ACTUALLY PAID DIRECTLY TO THE PROVIDER OF THOSE SERVICES BY MY ASSIGNEE. I UNDERSTAND THAT THE COMPANY BEARS NO RESPONSIBILITY OR LIABILTY FOR THE VALIDITY OR EFFECT OF THIS ASSIGNMENT OR FOR ANY PAYMENTS MADE BY THE COMPANY PRIOR TO RECEIPT OF SATISFACTORY PROOF OF PAYMENT BY THE ASSIGNEE. I HEREBY SPECIFICALLY RELEASE, AND AGREE TO INDEMNIFY, THE COMPANY FROM ANY AND ALL LIABILITY INCURRED FOR ANY SUCH PAYMENTS MADE.

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.

RHODE ISLAND: 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.

FOR RESIDENTS OF NEW YORK: 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, AND ANY PERSON WHO KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR COVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLE OR AN INSURANCE COMPANY 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 VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

FOR RESIDENTS OF PENNSYLVANIA: 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 CONCELAS 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.

FOR CLAIMANTS NOT RESIDING IN CALIFORNIA, RHODE ISLAND, NEW YORK, OR PENNSYLVANIA: 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.

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

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE:	DATE: