SEVENCORNERS

PROOF OF LOSS FORM & PAYMENT AUTHORIZATION INSTRUCTIONS

By completing and submitting the Proof of Loss Form, you will provide the necessary information for your claim to be properly processed by our claims depratment.

PROOF OF LOSS FORM INSTRUCTIONS

1. This form must be completed in full by the insured to be considered for Medical Expense Payment.
2. Attach a fully itemized copy of your bills and a complete description of charges for services provided, including the Claimant's/ Patient's Name, and Nature of Illness/Injury.
3. This form must be signed and dated in all applicable sections. In most cases, two signatures are required.
4. This form and all attached bills must be submitted to the address indicated below.
5. In most cases, a passport copy including entry/exit/visa stamps is required.
6. If you are seeking reimbursement for payments already made, please complete the attached Payment Authorization Form
7. Please complete all sections legibly and completely. If a question does not apply to you, please use n/a.

By completing and submitting the Payment Authorization Form, you will provide the necessary financial information to be reimbursed for your expenses.

PAYMENT AUTHORIZATION FORM INSTRUCTIONS

1. Please complete all sections legibly and completely. If a question does not apply to you, please use n/a.
2. Please sign and date appropriately.
3. For an ACH, if the bank is located in the United States, complete boxes 1 and 2. (*The names in box 1 and 2 must match.)*
4. For an ACH, if the bank is located outside of the United States, complete boxes 1 and 3. (*The names in box 1 and 3 must match.)*
5. For a wire transfer, complete boxes 1 and 3. (*The names in box 1 and 3 must match.)*
6. For a check, complete boxes 1 and 2. (*The names in box 1 and 2 must match.*
7. For more informaiton about how to file a claim visit: www.sevencorners.com/file-a-claim

CLAIMS DOCUMENTS MUST BE SIGNED AND SUBMITTED WITHIN 90 DAYS FROM THE DATE OF SERVICE
VIA POSTAL MAIL, FAX OR EMAIL ATTACHMENT TO:

Seven Corners, Inc.
Attn: Claims
303 Congressional Boulevard
Carmel, IN 46032 USA
U.S : 317-575-2656
Toll Free: 1(800)335-0477
Fax: (+01) 317-575-2256
Email: claims@sevencorners.com

PLEASE NOTE: Email attachments cannot be larger than 10 MB.

PROOF OF LOSS FORM

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.

1 - COVERAGE INFORMATION - *This information can be found on your Insurance I.D. Card*

Insurance Company:_____ Name of Group/Plan:_____ Policy/Certificate #_____

Coverage Effective Date:
(Month/Day/Year) _____ _____ _____

Coverage Termination Date:
(Month/Day/Year) _____ _____ _____

2 - PRIMARY INSURED INFORMATION

Name of Insured: _____
Date Of Birth (Month/Day/Year): _____ _____ _____
Sex: ☐ M ☐ F

3 - CLAIMANT/PATIENT INFORMATION

Name of Claimant: _____
Date Of Birth (Month/Day/Year): _____ _____ _____
Sex: ☐ M ☐ F

4 - CURRENT ADDRESS

Current Residence Address: _____
_____
_____
_____

Daytime Phone # _____
Email Address: _____
If Applicable, Date of Arrival in U.S.
(Month/Day/Year): _____ _____ _____

5 - PERMANENT ADDRESS

Permanent Address In Home Country: _____
_____
_____
_____

If Applicable, Date scheduled to return to Home Country:
(Month/Day/Year): _____ _____ _____

6 - MEDICAL INFORMATION

If Injured, provide details, such as how, when, and where injury occurred.

NAME OF CLAIMANT/PATIENT	**POLICY/CERTIFICATE #**
_____	_____

7 - If Illness, advise when and where symptoms first occurred and nature of illness:

8 - Name and Address of Consulting or Treating Physicians:

9 - Have you ever been treated for this Illness before? ☐ Y ☐ N

If Yes, When? _____

10 - Provide Name and Address of your Primary Care Physician in your Home Country:

11 - Indicate other Employer / Private/Government Medical Insurance coverage. (Include name, address, policy number and certificate number of Insurer):

12 - Please advise names of any prescription medications you are presently taking or took during the past 6 months not related to your injury or illness:

13 - Please advise names of any prescription medications you have been prescribed for your injury or illness:

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, relative or benefit plan administrator to furnish to Seven Corners, Inc. 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 the claim and copies of all 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 identified above. I authorize the group policyholder, employer or benefit plan administrators to provide Seven Corners, Inc. with financial and employment related information and documents. I agree that I will provide Seven Corners, Inc. with any medical records, or other records, requested by Seven Corners, Inc. to process the claim. I understand that my failure to provide requested documents to Seven Corners, Inc. may result in denial of the claim. I understand that failure by any of the above referenced entities or individuals to provide information or documents to Seven Corners, Inc. may result in denial of the claim. In addition, I hereby certify that the above information is true and correct to the best of my knowledge and belief. I understand that any false statements made on this form or omissions of information requested by this form may result in denial of the claim. I acknowledge and understand the Fraud Notices on Page 3 of this document.

_____ _____

Signature of Patient/Claimant or Parent, If Claimant is a Minor Date

PAYMENT AUTHORIZATION FORM

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2. For an ACH, if the bank is located outside of the United States, complete boxes 1 and 3. (The names in box 1 and 3 must match.)
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4. For a check, complete boxes 1 and 2. (The names in box 1 and 2 must match.

METHOD OF PAYMENT - *ONE MUST BE SELECTED*

☐ ACH — Only in U.S. $, Canada $ Euros & Pounds

☐ Check — Check will be written and shipped to person in "Contact Information" field.

☐ International Wire Transfer

1 - CONTACT INFORMATION

(P.O. Boxes are not accepted)

Name:_____

Physical/Street Address:_____

Email: _____ Telephone Number:_____

I authorize Seven Corners, Inc. to contact me using the email address I provided in this form to discuss and/or inform me of payment confirmation.

2 - US ACCOUNT INFORMATION - *COMPLETE FOR ACH PAYMENT IF BANK IS IN THE U.S. (NO FEES APPLIED)*

(Name in "Contact Information" must match name on bank account)

Account Type: ☐ Checking ☐ Savings

Account Holder(s) Name:_____ Full Bank Name: _____

Complete Bank Address:_____

ABA Routing Number: _____ Account Number:_____

3 - INTERNATIONAL / NON-US ACCOUNT INFORMATION - *COMPLETE FOR WIRE TRANSFER PAYMENT OR ACH OUTSIDE THE U.S.*

Preferred Reimbursement Currency:_____

Full Bank Name:_____ Branch Name/Number:_____

Complete Bank Address:_____

_____

Account Holder(s) Name:_____

(Exact, full, legal name(s) of account holder(s) as it appears on bank statements. Joint accounts require all names.)

Account Number:_____

Complete the fields below as appropriate for your specific account. Please contact your bank to confirm the exact information required to successfully receive a foreign funds transfer.

Routing Number:_____ SWIFT/BIC:_____

IBAN:_____ CLABE:_____

BSB:_____ Sort Code:_____

Other (please specify):_____

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 medical 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

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FRAUD NOTICES

General: 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.

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.

Arkansas, Louisiana, Maryland, West Virginia: 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

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.

Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Delaware, Idaho, Indiana: 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.

District of Columbia: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: 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.

Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another 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, and subjects the person to criminal and civil penalties.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

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 section 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject 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.

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.

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: WARNING: 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: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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.

Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: 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.

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