



- 1. PLEASE FULLY COMPLETE THIS FORM
- 2. ATTACH ITEMIZED BILLS
- 3. MAIL TO HSR

4100 Medical Parkway
 Carrollton, TX 75007
 Phone: (972) 512-5600 Fax: (972) 512-5820
 Toll Free (800) 345-0959

Underwritten By ACE American Insurance Company

E-mail: ACEClaims@hsri.com

FOR HSR USE ONLY: Claim Company # _____ Plan # _____ Location # _____

ACCIDENT AND SICKNESS CLAIM FORM/ GLOBAL

1. Coverage Effective Date: ____/____/____ Coverage Termination Date: ____/____/____
2. Name of Insured: _____ Date of Birth: ____/____/____ Gender M F
3. Name of Claimant/Dependent: _____ Date of Birth: ____/____/____ Gender M F
4. Is this a claim for a dependent? Yes No Relationship: _____
5. Current Residence Address: _____
6. Best Contact Phone Number: (____) _____ E-Mail Address: _____
7. Permanent Address (In Home Country): _____
8. Date of Arrival in U.S.: ____/____/____ Date Scheduled to Return to Home Country ____/____/____
9. Is this claim the result of an accident? Yes No If yes, give date of accident ____/____/____
10. Where did the accident occur? _____
11. How did the accident happen? _____
12. Description of illness or injury: _____
13. What was the date symptoms began: ____/____/____
14. Have you ever been treated for this illness before? Yes No
15. If yes, provide name and address of treating physician(s) and date(s) first consulted: _____

16. Provide Name and Address of your regular physician in your Home Country: _____

17. Please advise names of any prescription medications you are presently taking: _____
18. Is patient covered for benefits (other than this policy) by any of the following:
 Yes No Group Health Benefits of any kind through an employer, spouse's employer, or parent's employer
 Yes No Coverage of medical care expenses provided through any Federal, State, Provincial, or other Government Agency
19. If any of the above apply, please complete the following:
 Through whom is your coverage provided? (i.e. parent, spouse, etc.) _____

	Name	Relationship
Insurance Co. or Benefit Plan _____	Sponsor or Employer _____	
Insurance Co. Address _____	Sponsor Address _____	
Telephone (____) _____	Plan/Group Number _____	Sponsor Telephone (____) _____
20. I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon, or Pharmacist to release any information requested with respect to this claim.
 Date ____/____/____ Signature of Patient _____

I know it is a crime to fill out this form with facts I know are false or leave out facts I know are important. I certify that the information furnished by me in support of this claim is true and correct. I further acknowledge that I am legally obligated to pay for all medical expenses submitted for this claim in the absence of this health insurance plan.

Date ____/____/____ Signature of Student _____

Date ____/____/____ Signature of Patient _____

COMPLETE THIS SECTION ONLY IF YOU WISH THE BENEFITS TO GO DIRECTLY TO THE PROVIDER(S)

Authorization to Pay Benefits: I hereby authorize payment directly to any provider of service for which I am submitting attached billings and charges. For the expenses provided under my Group Medical Expense Benefits, I understand I am financially responsible for charges not covered by this authorization.

Date ____/____/____ Signature _____

FRAUD STATEMENTS

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, ARKANSAS, IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

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 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.

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.

DISTRICT OF COLUMBIA RESIDENTS: 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.

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.

MARYLAND: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

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: 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.

OREGON: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

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 act, which is a crime and subjects such person to criminal and civil penalties.

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 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.

VIRGINIA: Any person who, with the 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 may have violated state law.