Cambridge Administrators
5832 South 142nd St, Suite A
Omaha, NE 68137
Toll Free: (855) 868-7554 Fax: (402) 504-6447
Email: info@CambridgeAdministrators.com

Instructions for Submitting a Claim

1. Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance or medical payment plan. If the claimant is covered by any other health insurance or medical payment plan, they must first submit the claim to the primary insurance. After the primary insurance has paid benefits, then submit this claim form along with all Explanation of Benefits (EOBs) from the primary insurance.

2. This claim form must be submitted for each individual accident/sickness. A fully completed claim form is not necessary when submitting additional medical bills; only one claim form is needed per accident/sickness. The claim form must be submitted for each accident/sickness within 90 days of the occurrence.

3. Please ask your provider to submit all medical bills. The bills must be itemized for service. A physician's office should submit an invoice utilizing a CMS 1500. A hospital and/or emergency room should submit an invoice utilizing a UB04 (CMS 1500 and UB04 are universal billing forms supplied by the physician's office and/or hospital).
   If the provider will not submit the bill(s) directly, please request these forms from the provider(s) and attach to the claim form for submission. A balance due or patient statement is not acceptable and will only delay processing.

4. In the event that a claim is not submitted in full, or if additional information is needed, the claim will be closed and the additional information will be requested via US Mail. Please forward the requested information immediately so that we may finish adjudicating your claim in a swift manner. The explanation of benefits form advising what is needed will be sent to the address of the claimant listed on the claim form.

Claim Submission Checklist
Use the checklist below to assure a properly submitted medical claim is being sent:

☐ If the claimant has primary health insurance, has the claim been submitted first to the primary health insurance?

☐ If there is primary health insurance, are copies of EOBs (explanation of benefits) attached?

☐ Is the claim form completed in full by the claimant and signed?

☐ If bills are attached, are they in either a CMS 1500 or UB04 form?

☐ If any payment has been made by the patient, proof of payment must be included or payment will be made to the provider (doctor or hospital).

Send all information to:

Cambridge Administrators
5832 South 142nd St, Suite A
Omaha, NE 68137

Retain this page for future reference

Submit claim form and bills to:

Cambridge Administrators LLC
5832 South 142nd St, Suite A
Omaha, NE 68137
Toll Free: (855)868-7554 Fax: (402)504-6447
Email: info@CambridgeAdministrators.com

BERKLEY Accident and Health
a W. R. Berkley Company

WISE Worldwide International Student Exchange

Accident and Sickness Claim Form

Insurance coverage is underwritten by Berkley Life and Health Insurance Company, (domiciled in Iowa - California Certificate of Authority #08527) and/or StarNet Insurance Company (domiciled in Delaware - California Certificate of Authority #6978), 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690.

Section A Claimant Information

Group / Policyholder: WISE Foundation BTA L10100237 001 | Member ID:

Claimant Name: | Date of Birth: / / | Gender: (M/F)

Current Address:

Email Address: | Best contact phone number: ( )

Home Country Address:

Date of Arrival: / / | Date scheduled to return to home country: / /

Section B To be completed for Sickness Claims

Date of Sickness (month / day / year): / /

Date symptoms first noticed (month / day / year): / /

Description of symptoms or diagnosis:

Have you ever had the same or a similar condition? ☐ YES ☐ NO

If yes, date of first treatment (month / day / year): / /

Please provide name and address of treating physician:

Date of Last treatment: / / | Is treatment complete: ☐ YES ☐ NO

Please provide names of any prescription medications you are currently taking

Section C To be completed for Accident Claims

Date of Accident (month / day / year): / / | Time: ☐ a.m. ☐ p.m.

Type of injury (indicate part(s) of body injured - i.e., broken right arm, sprained left ankle, etc.)

Describe how accident happenned - give all possible details (use back of form if additional space is needed)

Continued on next page

Section C (continued)

Is this condition work related? ☐ YES ☐ NO If YES, please submit documents relating to work injury

If Yes, has workers compensation been filed? ☐ YES ☐ NO

If Yes, what is the status of the claim, and provide the phone number of the insurance company.

If No, please explain why it was not filed and have employer sign below

Employer's Signature:

Is this condition due to an motor vehicle accident? ☐ YES ☐ NO

If Yes, complete the information below regarding any motor vehicle insurance involved

Policyholder Name(s):

Policyholder ID number(s):

Name of Insurance Company(s):

Address of Insurance Company(s):

If police report was filed, please obtain and attach a copy.

Section D Other Coverage Information

Do you have other health insurance? ☐ YES ☐ NO If YES, complete below:

Policyholder Name (s):

Policyholder ID number(s):

Name of Other Insurance(s):

Address of Other Insurance(s):

Section E Authorization to Release Medical Information

I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to Berkley Group Companies: Berkley Life and Health Insurance Company, StarNet Insurance Company, Acadia Insurance Company, Great Divide Insurance Company, or its authorized Administrator or their legal representatives. Any information obtained will not be released by the Company, except to persons or organizations performing business or legal services in connection with my claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below (In CA, CT, GA, HIL, MA, MN, NC, NJ, OH, and VA authorization shall be valid during the duration of the claim). I understand that my authorized representative or I will receive a copy of this authorization upon request.

Warning: 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/or civil penalties. (Fraud language varies by state, please see below)

Name of Insured or Authorized representative: _____

Signature of Insured or Authorized representative: _____ Date: _____

FRAUD WARNING NOTICES

For residents of Alaska, Delaware and Idaho: 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.

For residents of 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.

For residents of 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.

For residents of 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.

For residents of 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.

For residents of 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.

For residents of 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.

For residents of 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.

For residents of Maine, Tennessee, Virginia and 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 may include imprisonment, fines or a denial of insurance benefits.

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

For residents of 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.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

For residents of 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.

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 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.

For residents of Ohio and Oklahoma: 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.

For residents of Oregon: 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.

For residents of 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.

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