

PROOF OF LOSS

NAME OF GROUP: INF Health Care Services
POLICY NUMBER: CC003938
CC003939

c/o Administrative Concepts Inc
Po Box 4000
Collegeville, PA 19426
Phone: 855-428-3425

ACCIDENT AND SICKNESS CLAIM FORM

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:
- Section B Fully Completed by the Attending Physician, or
- Fully Itemized Bills showing Claimant's Name, Nature of Illness/Injury, Description and Charge for each service provided.
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.
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

(PLEASE PRINT)

Coverage Effective Date ___/___/___ Coverage Termination Date: ___/___/___

1.) Name of Claimant: _____ Claimant's Date of Birth: ___/___/___ Sex: Male Female

2.) Current Residence Address: _____

3.) Date of arrival in U.S.: ___/___/___ Daytime phone number: () _____

4.) Permanent Address (In Home Country): _____

5.) If injury, give date injury occurred and details of the injury/accident: _____

6.) If Illness, advise when and where symptoms first occurred: Country _____ Date _____
Please indicate nature of the illness and/or describe your symptoms: _____

7.) Have you been treated for this illness or injury prior to the effective date of this insurance? _____
If yes, provide name and address of the treating Physician(s) and date(s) first consulted. _____

8.) Provide Name and Address of your Regular Physician in your Home Country: _____

9.) Were you taking any medications prior to the effective date of this insurance? _____ If yes, please provide the following:
Drug Name: _____ Drug Name: _____ Drug Name: _____
Prescribed for: _____ Prescribed for: _____ Prescribed for: _____
Physician Name: _____ Physician Name: _____ Physician Name: _____
Date 1st Prescribed: _____ Date 1st Prescribed: _____ Date 1st Prescribed: _____

10.) Do you have other health insurance? Yes ___ No ___ If yes, please provide the name, address and policy number of the Insurance: _____

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

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 Insurance 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 representative may request a copy of this authorization.

I authorize payment of medical benefits to the physician or supplier for service performed. 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 liability 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."

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 conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles 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 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."

For claimants not residing in California, 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.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE:

DATE:

IMPORTANT NOTICE

Notice to Alaska Claimants: 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.

Notice to Arizona Claimants: 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.

Notice to Arkansas Claimants: 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.

Notice to California Claimants: 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.

Notice to Colorado Claimants: 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.

Notice to Delaware Claimants: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.

Notice to District of Columbia Claimants: 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.

Notice to Florida Claimants WARNING: 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.

Notice to Idaho Claimants: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information, is guilty of a felony.

Notice to Indiana Claimants: 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.

Notice to Kentucky Claimants: 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.

Notice to Maine Claimants: 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.

Notice to Maryland Claimants: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Minnesota Claimants: A person who submits an application or files a claim with intent to defraud or helps commits a fraud against an insurer is guilty of a crime.

Notice to New Hampshire Claimants: 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.

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

Notice to New Mexico Claimants: 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.

Notice to New York Claimants Fraud 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 material 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.

Notice to Ohio Claimants: 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 is guilty of insurance fraud.

Notice to Oklahoma Claimants: 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.

Notice to Oregon Claimants WARNING: Any person who, knowingly and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud.

Notice to Pennsylvania Claimants Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 such person to criminal and civil penalties.

Notice to Rhode Island Claimants WARNING: 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.

Notice to Virginia Claimants: 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.

Notice to Claimants in all other states: Any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Section B (Completed by Providers) INDIA NETWORK HEALTH INSURANCE CLAIM FORM

CLAIMANT INFORMATION

1. PATIENT'S NAME (First Name, Middle Initial, Last Name)		2. PATIENT'S DATE OF BIRTH MM / DD / YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>	3. INSURED'S NAME (First Name, Middle Initial, Last Name)	
4. PATIENT'S ADDRESS (No., Street) CITY _____ STATE _____			5. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/>		6. INSURED'S ADDRESS (No., Street) CITY _____ STATE _____	
ZIP CODE _____	TELEPHONE NO. () _____		7. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		ZIP CODE _____	TELEPHONE NO. () _____
8. IS PATIENT'S CONDITION RELATED TO: A. AN AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> B. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>						

9. PATIENT'S OR AUTHORIZED PERSONS' SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		10. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to undersigned physician or supplier for service described below.	
Signature _____	Date _____	Signature _____	Date _____

11. DATE OF CURRENT: MM / DD / YY	ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	12. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: GIVE FIRST DATE: MM / DD / YY

13. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	13a. I.D. NUMBER OF REFERRING PHYSICIAN	14. Hospitalization Dates Related to Current Services MM / DD / YY FROM: / / TO: / /
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15. RESERVED FOR LOCAL USE	16. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>
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17. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1 _____ 3 _____

2 _____ 4 _____

18. A		B	C	D		E	F	G	H	I	J	K
DATE(S) OF SERVICE		Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	DPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
FROM MM/DD/YY	TO MM/DD/YY			(Explain Unusual Circumstances)	CPT/HCPCS							

19. FEDERAL TAX I.D. NUMBER SSN _____ EIN _____	20. PATIENT'S ACCOUNT NO.	21. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	22. TOTAL CHARGE \$ _____	23. AMOUNT PAID \$ _____	24. BALANCE DUE \$ _____
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25. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements apply to this bill and are made a part thereof.) SIGNED _____ DATE _____	26. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office).	27. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE # PIN# _____ GRP# _____
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PLACE OF SERVICE CODES 1-(H) - INPATIENT HOSPITAL 2-(OH) - OUTPATIENT HOSPITAL 3-(O) - DOCTOR'S OFFICE	4-(H)-PATIENT'S HOME 5- -DAYCARE FACILITY (PSY) 6- -NIGHT CARE FACILITY(PSY)	7-(NH) NURSING HOME 8-(SNF)-SKILLED NURSING FACILITY 9- -AMBULANCE	O-(OL)-OTHER LOCATIONS A-(IL)-INDEPENDENT LABORATORY B- -OTHER
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