The Insurance Co. of the State of Pennsylvania
AMA & Associates
P. O. Box 659570
San Antonio, TX 78265-9570
800-456-7480 / Fax: 210-822-4113

PROOF OF LOSS

NAME OF GROUP:	**University of Illinois at Chicago** **Tutorial Intensive English**
POLICY NUMBER:	**GLB – 9709502 (0810-22E12-2478)**

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.) The following MUST BE provided: ***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: _____/_____/____

Are you a United States citizen? No ☐ Yes ☐ **Social Security #:** _____-_____-_____

1.) Name of Claimant: _____ Claimant's Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female
Month Day Year

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 of injury and details of how the injury occurred:** / /
MM / DD / YY **INJURY DETAILS**

Did injury occur during practice or play of sports? Yes ☐ No ☐
If yes, please check: ☐ Club ☐ Intercollegiate ☐ Recreational

Name of Sport _____

6**.) If Illness, please indicate nature of the illness and/or your symptoms:**

Please advise when and where illness symptoms first occurred:

Country: **Date symptoms first occurred:** / /

7.) Have you been treated for this illness or injury prior to the effective date of this insurance? _____ **MM / DD / YY**
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: _____
(If the answer to #7 above is NO, this is not applicable.)

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 NOT APPLICABLE (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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE: DATE: