SEVENCORNERS

CLAIM FORM

EF PROGRAM NAME

☐ EF Educational Tours ☐ Go Ahead Tours ☐ College Break ☐ College Study Tours

PERSONAL INFORMATION

Tour Participant's First Name	Last Name	Departure Date

Gender	Account/Customer Number	Phone number
☐ Male ☐ Female		

E-mail address (only if the claims agent can contact you by e-mail)

Home address

Street	City	State	Zip Code

LOSS INFORMATION AND OUT-OF-POCKET EXPENSES

After completing this section, attach copies of all travel documents (original airline tickets, medical bills, hotel receipts, travel itinerary, etc.), supporting penalities, added costs or non-refundable charges incurred by you during your trip.

Company name (airline/hotel/cruise etc.)	Amount paid	Amount of loss	Have you received (non-refundable amount)	If so, from whom reimbursement	How much
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		
TOTAL					

TRIP INTERRUPTION

Interruption date (MM/DD/YY)	Place	Duration	Hours	Min

If Interruption involves another party	Name of party involved	Relationship to Participant

Reason for Interruption

IF INTERRUPTION DUE TO MEDICAL REASONS

Name of person having sickness or injury	His/Her date of Birth (MM/DD/YY)

His/Her Relationship to Participant	Date Sickness or Injury began (MM/DD/YY)	Date Ended (MM/DD/YY)

Nature of Sickness or Injury (If Injury, describe accident, including date and place)

Period of Hospitalization (if applicable)	From (MM/DD/YY)	To (MM/DD/YY)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION To be Completed by Patient

In order to process a claim for benefits, I AUTHORIZE any physician, hospital, or other Medical Provider to release to Seven Corners, or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed two and one-half years from the date signed. I understand I have a right to receive a copy of this authorization.

Date: _____ Signature: _____
(Signature of Person Suffering Illness or Accident or legally authorized representative)

ATTENDING PHYSICIAN'S STATEMENT To be Completed by Physician only

Patient Name | Date of birth (MM/DD/YY)

Date symptoms first appeared or accident occured

Date of first treatment (MM/DD/YY) | Was patient treated by someone else? | If so, by whom and when?

Diagnosis resulted in cancellation | Are you patient's usual medical practitioner?

Medical history of this or any associated condition

Did you prohibit patient's traveling by air or otherwise due to this injury/illness (if so date)?

Date completed (MM/DD/YY) | Physician's signature | Taxpayer ID Number

ILLNESS AND ACCIDENT (If no other coverage, please forward original medical bills for treatment received while on your covered trip.)

Do you have any other type of coverage? | If so, please provide the company name and address

Type of Policy | Policy # | Contact | Phone

Have you filled a claim with their office at this time? Yes ☐ No ☐

If yes, please note their response

If not, why not

Total amount you are claiming under this plan

ILLNESS/ACCIDENT STATEMENT To be Completed by Patient

Name of person having illness or injury | His/Her date of Birth (MM/DD/YY)

His/Her Relationship to Participant | Date Sickness or Injury began (MM/DD/YY) | Date Ended (MM/DD/YY)

Nature of Illness or Injury (If Injury, describe accident, including date and place)

Period of Hospitalization (if applicable) | From (MM/DD/YY) | To (MM/DD/YY)

TRAVEL AND BAGGAGE DELAY (Proof of the delay from the airline needs to be provided. Also, include receipts for necessary purchases as a result of the delay.)

Delay date (MM/DD/YY) | Place | Duration | Hours | Min

Describe the nature of the delay

BAGGAGE AND PERSONAL EFFECTS

Type of damage or loss

Describe what happened

Specification of damaged or lost property **(Attach police report, report from airline, receipts or other proof of ownership of property.)**

Detailed description of damaged or lost property (please add a separate paper, if needed)	Purchase price and currency	Date of purchase	Claim for compensation
			Total amount

OTHER INSURANCE/AUTHORIZATION

Do you have any other type of insurance? If so, please provide the Company Name and Address

Type of Policy Policy # Contact Phone

I AUTHORIZE any insurance company, physician, hospital, and other health care providers, any travel organization or agency, airline carrier, rental agency, hotel, mote l, or similar entity providing lodging on a rental/lease basis or any other person who may have knowledge regarding this claim, to release any information requested regarding this claim and the loss reported.

I UNDERSTAND that the Travel Benefits Plan, administered by Seven Corners, does not cover losses caused by injury or sickness to the extent that they are eligible under a primary group insurance, group-type insurance, prepayment, group practice or individual practice coverage and coverage other than school accident-type coverage, now therefore, as a condition for my receipt of immediate benefits under the Seven Corners plan, for claims in connection with injury or sickness beginning on the date shown above, I irrevocably agreed to: (a) assign all benefits payable from my primary insurer to Seven Corners; (b) promptly reimburse Seven Corners if and when I receive payment(s) from my primary insurance; (c) allow Seven Corners to file a claim with my primary insurer to receive direct reimbursement; and (d) when requested by Seven Corners, to furnish Seven Corners with copies of my primary insurer's schedule of benefits.

I UNDERSTAND the information obtained by use of the authorization, will be used by Seven Corners to determine eligibility for benefits under th is plan. Any information obtained will not be released by Seven Corners to any person or organization
EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I further authorize.

I KNOW that I may request to receive a copy of the Authorization. I AGREE that a photographic copy of this authorization is as valid as the original. I AGREE that this Authorization shall be valid for tw o and one half years from the date shown below. I UNDERSTAND that it is illegal to knowingly file a false or fraudulent claim or to knowingly help someone else file one. I h ave read and understand the Fraud Notices on page 4 of this document.

Date: _____ Signed:_____

SEND COMPLETED CLAIM FORM WITH ALL SUPPORTING DOCUMENTATION TO:

Seven Corners, Inc.
Attn. Claims Dept.
303 Congressional Boulevard
Carmel, IN 46032

Phone 317 818 2808
Fax 317 815 5984
E-mail assist@sevencorners.com

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: 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.