BERKLEY Accident and Health
a W. R. Berkley Company

HSR
Health Special Risk, Inc.

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Toll Free (866) 523-3269

Policy Number: BTA L10100244 001

Policy Name: Church of the Nazarene

1. PLEASE FULLY COMPLETE THIS FOR
2. ATTACH ITEMIZED BILLS
3. MAIL TO *HSR*
E-mail: Berkley@HSRI.com

MEDICAL/SICKNESS CLAIM FORM

SECTION A. EMPLOYEE/PATIENT INFORMATION

Employer: _____ Policy Number: _____

Employee's Name _____ Employee's Date of Birth _____

Patient's Name _____ Patient's Date of Birth _____

Home Address _____

Please provide telephone and facsimile numbers, with country and city codes.

Home #_____Work # _____ Fax #_____ E-mail_____

Manager's Name _____Work #_____ Fax # _____ E-mail_____

SECTION B. TRAVEL INFORMATION *Please complete this section.*

My Business location is in (country of employment) _____

I / we left the above country on (Day / Month / Year) _____

I / we visited the following countries _____

I / we are expected to return home on (Day / Month / Year) _____

The purpose of my / our trip was _____

SECTION C. COMPLETE THIS SECTION FOR ACCIDENT CLAIM

Exact nature of injury: _____

Date and hour of occurrence: _____

Was the injury due to practice or play of a sport? ❑ Yes ❑ No

Which sport? ❑ Intercollegiate ❑ Intramural ❑ Club ❑ Other

Is condition work related? ❑ Yes ❑ No

Is condition due to auto accident ❑ Yes ❑ No

If yes, please attach detailed policy information on all motor vehicles involved in accident.

Were you treated in the Health Service for this condition? ❑ Yes ❑ No

Seen by: _____ Date: _____

If your claim is for services outside of the Health Service, were you referred? ❑ Yes ❑ No

SECTION D. COMPLETE THIS SECTION FOR SICKNESS CLAIM

Date of sickness: _____

Date symptoms first noticed: _____

If pregnancy, date of last menstrual period: _____

What is the exact nature of the sickness? _____

Have you ever had the same or similar condition? ❑ Yes ❑ No

If yes, date of first treatment: _____

Date of last treatment: _____

SECTION E. PAYMENT INFORMATION *Please complete either Option #1, Option # 2 or Option #3*

OPTION #1 **Payment to EMPLOYEE** - ***Please indicate where you wish the payment to be sent and in what currency.***

❑**Your home address as listed above** ❑**Direct deposit to your bank account**

Name on account: _____ Account #: _____

Bank Name: _____ Swift Code: _____

Bank Address: _____ Currency: _____

IBAN: _____

OPTION #2 - **Payment to a Provider, e.g. hospital, physician**

Please complete Provider's name and address in Section G of this Claim Form

OPTION #3 - **Payment to the Employer**

Employer's Name: _____

Employer's Address: _____

Payment Authorization: I authorize payment directly to me or to the healthcare provider in Section G of this Claim Form.

EMPLOYEE'S SIGNATURE:_____DATE: _____

Patient's Signature and Release (Parent or Guardian, if claim is for a minor), I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine claim payment

PATIENT'S SIGNATURE: _____ DATE:_____

SECTION F. OTHER COVERAGE INFORMATION

Complete only if the claim is for a dependent and/or other coverage is in effect or if the claim is accident or work related.

Do you have any other insurance? ❑ Yes ❑ No If yes, please provide source of insurance.

Please indicate source _____

Is this claim accident related? ❑ Yes ❑ No Is this claim work related? ❑ Yes ❑ No

If yes, please provide documents relating to accident or work injury.

If claim is due to an accident, are you seeking reimbursement from another source? ❑ Yes ❑ No

Please indicate source _____

Spouse's name _____ Spouse's insurance company _____

Spouse's employer and telephone # _____

Dependent's date of birth _____

SECTION G. PHYSICIAN OR PROVIDER *Please complete this section.*

Name, address, and telephone # of physician or provider of service _____

_____

_____

_____

Diagnosis or nature of illness or injury _____

Date of illness (first symptom) or injury _____ Date first consulted for this condition _____

Hospital confinement dates: From _____ To _____ Date able to return to work _____

Total disability dates: From _____ To _____ Partial disability dates: From _____ To _____

Patient's account # _____ Amount paid _____ Balance due _____

Place of service _____

Diagnosis code and description _____

Date of Service	Procedure code and description/ Predetermination of benefits	Charges	Total charges

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 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 *agree* that a photographic copy of this Authorization shall be a valid as the original.
I understand that I or my authorized representative may request a copy of this authorization.
I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative	**Relationship, If Other Than Insured**	**Dated**

Address:

FRAUD STATEMENTS

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

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.

Alaska and 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, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and 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 &Rhode Island: 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.

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.

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: 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.

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.

Georgia: Any natural person who knowingly or willfully

1) Makes or aids in the making of any false or fraudulent statement or representation of any material fact or thing:
    a. In any written statement;
    b. In the filing of a claim; or
    c. In the receiving of money for an application for a policy of insurance for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer;
2) Receives money for the purpose of purchasing insurance and converts such money to such persons own benefit;
3) Issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders; or
4) Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement for the purpose of fraudulently obtaining money or benefit from an insurer commits the crime of insurance fraud.

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, defrauds, 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 and 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.

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: 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.

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.