ACCIDENT QUESTIONAIRE

INSURED INFORMATION:

ID Number:	**Name Primary Insured:**		
Name of Claimant/Patient:	**Date of Birth of Patient:** M/D/Y		
Work Phone:	**Fax #:**	**Home Phone #:**	
Email Address:	**Social Security Number of Claimant/Patient:**		
Address:	**City:**	**State:**	**Zip Code:**

DESCRIPTION OF INJURY/ILLNESS:

Was the injury or illness: Auto/Motorcycle ❑ Work Related ❑ Other Accident ❑	
Date of accident/illness: M/D/Y	**Location of accident/illness:**
Describe the injury or illness and how it happened: **Is this illness/condition related to a work accident? ❑Yes ❑No** **If yes, have you applied for workers compensation, and please provide claim number?** **Did this illness/condition involve a motor vehicle? ❑Yes ❑No** **If yes, please provide names of all parties involved, including insurance carriers and policy/claim numbers including the dates of accident:** **Was a police report filed? ❑Yes ❑No** **If yes, Name and Number of Police Department, and number of report:**	

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.

Signature: _____ **Date:** _____

(Signature of Person Suffering Illness or Injury or legally authorized representative)

AUTHORIZATION:

I AUTHORIZE any insurance company, physician, hospital, and other health care providers, any travel organization or agency, airline carrier, rental agency, hotel, motel, 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 Beacon Series Travel Medical Plan, administered by Azimuth Risk Solutions, LLC., does not cover losses caused by injury or sickness to the extent that they are eligible under this travel medical insurance policy wording, now therefore, as a condition for my receipt of immediate benefits under the Beacon Series 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 Azimuth Risk Solutions, LLC; (b) promptly reimburse Azimuth Risk Solutions, LLC if and when I receive payment(s) from my primary insurance; (c) allow Azimuth Risk Solutions, LLC to file a claim with my primary insurer to receive direct reimbursement; and (d) when requested by Azimuth Risk Solutions, LLC to furnish Azimuth Risk Solutions, LLC with copies of my primary insurer's schedule of benefits.

I UNDERSTAND the information obtained by use of the authorization, will be used by Azimuth Risk Solutions, LLC to determine eligibility for benefits under this plan. Any information obtained will not be released by Azimuth Risk Solutions, LLC 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 two 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 have read and understand the Fraud Notices on page 4 of this document.

Signature:_____Date:_____

Mailing Instructions:
Send this form and any accompanying documentation to:

Korak Healthsource, Inc. C/O
Azimuth Risk Solutions, LLC.
P. O. Box 206
Forest Hill, MD 21050
Phone: 317-644-6291/888-201-8850
Fax: 317-423-9620/888-201-8851