AZIMUTH CLAIM FORM PROCEDURES

The Azimuth Claim Form is provided with all fulfillment documents issued by the Scheme Administrator. The Azimuth Claim Form is also available at all times via the Scheme Administrator's website at www.azimuthrisk.com. When the Scheme Administrator receives notice of a claim for Benefits under this insurance but the Azimuth Claim Form for the corresponding Illness, Condition or Injury has not been submitted, the Scheme Administrator will send Participating Member the Explanation of Benefits (EOB) along with the requested Azimuth Claim Form for filing a Proof of Claim. An Azimuth Claim Form will need to be submitted for each new Illness, Condition or Injury a Participating Member receives treatment. Each Azimuth Claim Form submitted must be duly completed and signed for consideration of coverage.

PROOF OF CLAIM PROCEDURES

The following items must be submitted to be considered a complete Proof of Claim eligible for consideration of coverage:

- **A duly completed and signed Claim Form; and**
- **Itemized bill(s) from all Physicians, Hospitals, other healthcare providers or pharmacies related to the claim(s); and**
- **Receipts for any Expenses Incurred or paid by or on behalf of the Participating Member with respect to the claim(s); and**
- **The Participating Member(s) shall have ninety (90) days from the date a claim is incurred to submit a complete Proof of Claim; and**
- **Complete Proof of Claim(s) can be submitted by Email, Mail or Fax to:**
  Email: service@azimuthrisk.com
  Mail: Azimuth Risk Solutions
  PO Box 627
  Indianapolis, IN 46206
  Fax: 1-317-423-9620/1-888-201-8851
- **The Scheme Administrator may deny coverage for any Proof of Claim submitted thereafter or for an incomplete Proof of Claims. All claim decisions made by or on behalf of the Scheme Administrator are with the express consent of Underwriters; and**

For any additional questions or concerns, please contact Azimuth Risk Solutions at 1-317-622-6291/888-201-8850.

AZIMUTH CLAIM FORM QUESTIONNAIRE

Part 1 - Please complete the section below. All communications of this claim will be sent to the address below.			
Is this claim related to (please check one): ☐ **Illness** ☐ **Condition** ☐ **Injury** ☐ **Dental** ☐ **Other**			
Claimant/Patient Name:		**Policy holder's Name:**	
Date of Birth (M/D/Y):	☐ **Male** ☐ **Female**	**Date of Birth (M/D/Y):**	☐ **Male** ☐ **Female**
Complete Mailing Address for all correspondence:			
City, State:	**Postal Code:**	**Country:**	
Email:	**Home/Cell Phone:**	**Work Phone:**	
Destination Country(ies):			
Azimuth ID or Group Number:	**Citizenship of Claimant:**	**Home Country:**	
Full-Time Student: ☐ **Yes** ☐ **No**			
If yes, please provide the name and address of the school:			

Part 2 -If covered by another insurance plan please complete the section below		
Do you have additional Insurance? ☐ **Yes** ☐ **No**		
Name of Primary Insured of other insurance company:	**Date of Birth (M/D/Y):**	
Please provide name of other insurance company:		
Mailing address of other insurance company:		
Policy Number of other insurance plan:	**Group Number of other insurance plan:**	

Part 3 - Please complete all applicable questions below, although more information may be requested. (If you need additional space, please attach a separate sheet)

1. **What medical Illness, Condition or Injury are you being treated for?**
   Please describe all symptoms.

2. **When did the first symptom of this Illness, Condition or Injury begin (M/D/Y)?**

3. **Have you ever been treated for this Illness, Condition or Injury before?** ☐**Yes** ☐**No**
   If yes, please list the treatment dates (M/D/Y) and complete question #4.

4. **List the names and addresses of all the providers you have seen for this Illness, Condition or Injury:**

5. **Is this Illness, Condition or Injury related to a work accident?** ☐ **Yes** ☐ **No**
   If yes, have you applied for workers compensation? ☐ **Yes** ☐ **No**
   Date of accident (M/D/Y):

6. **Did your Injury involve a motor vehicle accident?** ☐ **Yes** ☐ **No**
   If yes, please provide the name of all parties involved, insurance carriers and policy numbers, and the date of the accident (M/D/Y):

7. **Was a police report filed?** ☐ **Yes** ☐ **No**
   If yes, please submit a copy of the police/accident report with this claim form.

Part 4 - Please complete this section for all services incurred outside of the US. List each service/claim separately. (If you need additional space, please attach a separate sheet)

Illness, Condition or Injury:	Procedure(s), Treatment or Medication(s)	Physician/Facility, Address & Phone #:	Date of service (M/D/Y):	Total Charge Paid:	Currency Paid:

Part 5- Authorization, please complete for all claims.

I verify all information contained in this form is true, correct and complete to the best of my knowledge.

The undersigned authorizes any doctor, medical practitioner, hospital, clinic, health facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, or insurance or benefit administrator or any other entity having information as to the care, advice, treatment, diagnosis, or physical or mental condition of any family member listed on this Application to release said information to Azimuth Risk Solutions.

Notice: Any false statement, concealment, or fraud shall render this insurance null and void and claims hereunder shall be forfeited.

Print Name of Primary Insured_____**Date (M/D/Y)** _____

Signature of Insured, or Guardian_____**Date (M/D/Y)** _____