AIG Travel Assist

HSR
Health Special Risk, Inc.

Wells Fargo Study Abroad Inbound/Outbound Insurance Program

Trip Cancellation/Interruption Baggage Loss

1. Please fully complete this form
2. Attach itemized bills
3. Mail to: *Health Special Risk, Inc.*

Email: WFstudyabroad@hsri.com

HSR Plaza
4100 Medical Parkway
Carrollton, Texas 75007
Telephone (972) 512-5600, Fax (972) 512-5820
Toll Free1-866-523-3183

FOR *HSR* USE ONLY: Claim Company #_____ **Plan #** _____ **Location #** _____

TO BE COMPLETED BY STUDENT

School Name: _____ Policy #_____

1. Student Name _____ Social Security Number _____-_____-_____ Date of Birth_____-_____-_____

2. Mailing Address _____
Number Street City State Zip

3. Permanent Address _____
Number Street City State Zip

4. Best Contact Phone Number, Including Area Code (_____) _____ Email: _____

5. Gender ☐ Male ☐ Female 6. Patient Status ☐ Single ☐ Married

7. Is this claim for a dependent? ☐ Yes ☐ No If yes, give name _____

Relationship_____ Date of Birth _____-_____-_____

8. Describe the conditions that caused this claim: (Select one and attach additional pages if needed):
☐ Trip Cancellation/Interruption ☐ Baggage Loss ☐ Personal Property

_____

9. If this is the result of an illness, has the patient been treated for this condition in the last six months? ☐ Yes ☐ No ☐ N/A

If yes, give condition(s) treated for and date(s) of treatment_____

10. Is this claim the result of an accident? ☐ Yes ☐ No If yes, give date of accident _____-_____-_____

Where did the accident occur? _____

How did the accident happen? _____

11. Is this claim the result of a work related injury? ☐ Yes ☐ No

12. Is the patient covered for benefits (other than this policy) by any of the following?

☐ Yes ☐ No Any individual, Blanket or Short Term Medical Insurance?

☐ Yes ☐ No Group Health Benefits of an kind through an employer, spouse's employer or parent's employer?

☐ Yes ☐ No Coverage of medical care expenses provided through any Federal, State, Provincial, or other Government Agency?

If any of the above apply, please complete the following:

Through whom is your coverage provided? (i.e. parent, spouse, etc.) _____
Name Relationship

Insurance Co. or Benefit Plan _____ Sponsor or Employer _____

Insurance Co. Address _____ Sponsor Address _____

Telephone (_____) _____ Plan/Group Number _____ Sponsor Telephone (_____)_____

I know it is a crime to fill out this form with facts I know are false or leave out facts I know are important. I certify that the information furnished by me in support of this claim is true and correct. I further acknowledge that I am legally obligated to pay for all medical expenses submitted for this claim in the absence of this health insurance plan.

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

SIGNATURE _____ **DATE** _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ **DATE** _____

PLEASE SEE CLAIM FILING INSTRUCTIONS ON THE REVERSE SIDE

MultiPlan

CLAIM FILING INSTRUCTIONS

WHEN TO FILE A CLAIM:

1. An initial claim is being submitted for a different family member.

2. A new claim is being submitted for a completely different illness or injury.

HOW TO FILE A CLAIM:

1. Complete the applicable items on the reverse side.

2. Promptly mail this form with any itemized bills to Health Special Risk, Inc.

3. If you receive additional bills on this claim after you have mailed this form, it is not necessary to complete another form.

4. Identify bills by adding the following information:

    - College's Name and Policy Number
    - Student's Name and Social Security Number
    - Patient's Name

MAIL ALL CLAIMS TO:

HSR
Health Special Risk, Inc.

Health Special Risk, Inc.
4100 Medical Parkway
Carrollton, TX 75007

Please remember to always make a copy of your claim forms before mailing to our office.