



1. Please fully complete this form, 2; file separate form(s) for family member(s), if applicable.
 2. Attach itemized bills and EOBs
 3. Mail to HSR

Email: Claims@hsri.com

HSR Plaza II
 4100 Medical Parkway
 Carrollton, Texas 75007
 Phone: (972) 512-5600
 Fax: (972) 512-5820
 Toll Free (866) 523-3186

Policyholder: _____

Policy Number: _____

CORE TRAVEL BLANKET ACCIDENT/SICKNESS CLAIM FORM

1. Your Name:		2. Date of Birth:		3. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		4. Program Country/Location		5. Social Security #:	
6. Name of Person Suffering Injury or Sickness:					7. His/Her Relationship to You:				
8. Your Address (include number and street, city, state, zip):									
9. Best Daytime Contact Telephone Number(s), include area code:					10. Name of Spouse:				
11. Is this claim the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No					12. If yes, give the date of the accident:				
13. Where did the accident/sickness occur?									
14. Describe how the accident/sickness happened (give all possible details):									
15. Describe the nature of the accident/sickness (give all possible details: e.g. broken arm, sprained ankle):									
16. For accident/sickness occurring in the U.S., number of miles from your home when accident/sickness occurred:					17. Scheduled Departure Date:			18. Scheduled Return Date:	
19. Was this accident the result of your Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No				20. Will you file for Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No			21. Date First Treated:		
22. Name and Address of Physician who first treated this condition (include number and street, city, state, zip):									
23. If treated in a hospital emergency room, provide the name and address of hospital (include number and street, city, state, zip):									
24. Exact amount you are claiming under this plan:									

Medical Authorization - Please sign the "Authorization for Release of Medical Information", as we may request a copy of your medical records.

Authorization to Pay Benefits to Provider/Authorization for Release of Medical Information

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. **(if not signed, submit proof of payment)**

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 _____

NOTE TO ALL PARTIES COMPLETING THIS FORM: Any person who, with intent to defraud or knowing that he/she 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.

By entering your name above, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.

FRAUD STATEMENTS

Important Notice

- ❖ ***In General, and specifically for residents of Arkansas, Louisiana, Rhode Island and 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.
- ❖ ***For Residents of Alabama:*** 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 restitution fines and confinement in prison, or any combination thereof.
- ❖ ***For residents of 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.
- ❖ ***For residents of the 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.
- ❖ ***For residents of 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.
- ❖ ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
- ❖ ***For residents of Maine, Tennessee, Virginia and Washington:*** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- ❖ ***For residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.
- ❖ ***For residents of Maryland :*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ❖ ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- ❖ ***For residents of 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.
- ❖ ***For residents of 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.
- ❖ ***For residents of 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.
- ❖ ***For residents of 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.
- ❖ ***For residents of 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.