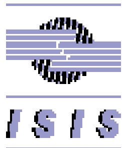

Indemnification (Claim) Form – Medical Expenses

Instructions: Please complete form completely.
Attach itemized bill for expenses and mail form and attachments to:

Global Benefits, Inc.
1030 15th Street NW, Suite 200
Washington, DC 20005

For claims status or benefits call:
(800) 633-1860 or (202) 898-0944

Please print clearly

Name: ____

Group Name or Number______________________________ Certificate #________________

Date of Birth: __________________ Check one - Male: ________ Female: ________

Permanent Address (in Country of Origin): ______________________________________

State/Country: ____

Temporary Address (on Travel): ______________________________City________________

State/Country: _____________________Zip: ________From: ___/___/___To: ___/___/___

Nature of Illness/Accident: ____

Date a Doctor was first seen for this condition: _____/_____/_____

Doctors name & address____

Was hospitalization required? Yes_____ No _____ Name of Hospital: ________________________

Has a doctor been seen for this condition in the past? Yes_____ No _____ Dates: ________________

Doctor's Name and Address: ____

If claim is due to an accident, please provide the following:

Date of Accident: _____/_____/_____ Where did Accident occur? ___________________________

How did the Accident happen? ____

I hereby certify that the foregoing statements, including any accompanying statements are true and complete to the best of my knowledge. I understand that this information will be used to evaluate and determine the eligibility of claims for either myself, or my dependents and all information will be held in strict confidence. I understand that any false or misleading information or the omission of facts regarding the conditions, dates and/or medications taken by the patient could result in nonpayment of claims submitted. In addition, I authorize the release of any medical information necessary to process claims on my behalf to Global Benefits, Inc. I permit a copy of this authorization to release information to be used as a valid authorization for any physician, hospital or other medical provider to forward any requested information, including full copies of their records, to Global Benefits Inc., for any medical treatment, or services rendered, regarding me, or any of my minor dependents.

X________________________________ X________________________________
Signature of Insured Person Signature of Patient (if other than insured)

Date: ________________________