

Insurance Company of the State of PA
C/O MCA Administrators, Inc
P.O. Box 6540
Harrisburg, Pa 17112
1-800-427-9308

PROOF OF LOSS

NAME OF GROUP:

POLICY NUMBER:

ACCIDENT AND SICKNESS CLAIM FORM/ GLOBAL

INSTRUCTIONS:

- 1.) This form is to be used when filing a claim for reimbursement of Medical Expenses.
- 2.) Section A must be completed by the Insured in full.
- 3.) One of the following must be provided:
 - Section B Fully Completed by the Attending Physician, or
 - Fully Itemized Bills showing Claimant's Name, Nature of Illness/Injury, Description and Charge for each service provided.
- 4.) This form must be signed and dated in all applicable sections.
- 5.) This form and all attached bills must be submitted to the address indicated above.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A

Coverage Effective Date ____/____/____ Coverage Termination Date: ____/____/____ Certificate Number ____
(If applicable)

Social Security #: ____-____-____

1.) Name of Claimant: _____ Claimant's Date of Birth: ____/____/____ Sex: Male Female
(PLEASE PRINT)

2.) Current Residence Address: _____

3.) Date of arrival in U.S.: ____/____/____ Daytime phone number: () _____

4.) Permanent Address (In Home Country): _____

5.) If injury, give date injury occurred and details of the injury/accident: _____

6.) If Illness, advise when and where symptoms first occurred: Country _____ Date _____
Please indicate nature of the illness and/or describe your symptoms: _____

7.) Have you been treated for this illness or injury prior to the effective date of this insurance? _____
If yes, provide name and address of the treating Physician(s) and date(s) first consulted.

9.) Provide Name and Address of your Regular Physician in your Home Country: _____

10.) Were you taking any medications prior to the effective date of this insurance? _____ If yes, please provide the following:
Drug Name: _____ Drug Name: _____ Drug Name: _____
Prescribed for: _____ Prescribed for: _____ Prescribed for: _____
Physician Name: _____ Physician Name: _____ Physician Name: _____
Date 1st Prescribed: _____ Date 1st Prescribed: _____ Date 1st Prescribed: _____

11.) Do you have other health insurance? Yes ____ No ____ If yes, please provide the name, address and policy number of the Insurance: _____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I authorize payment of medical benefits to the physician or supplier for service performed. YES NO

Optional Limited Assignment

I hereby make a limited assignment to _____ (my "Assignee") of the right to receive the benefits due for those covered medical expenses incurred by me and actually paid directly to the provider of those services by my Assignee. I understand that the Company bears no responsibility or liability for the validity or effect of this assignment or for any payments made by the Company prior to receipt of satisfactory proof of payment by the Assignee. I hereby specifically release, and agree to indemnify, the Company from any and all liability incurred for any such payments made.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE: _____

DATE: _____

