WorldTrips
Box No. 2005
Farmington Hills, MI 48333-2005
800-605-2282 / 1-317-262-2132

INDIANA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Claimant's Statement and Authorization

INSTRUCTIONS

COMPLETE ALL APPLICABLE PARTS OF THIS FORM.

NOTE: *Only one Claimant's Statement and Authorization form is required for each episode of care. If you have already submitted a form related to the incident for which you are claiming, an additional Claimant's Statement is not needed.*

MEDICAL SERVICES OUTSIDE THE UNITED STATES

If medical services took place outside the United States, please complete this form along with Supplement C. Attach all original itemized bills for services and supplies. Please verify that the documents indicate your name, date of service, diagnosis, and the charge for each service. If you have already paid for these services, please include receipts showing payment.

FORM SUBMISSION OPTIONS

Paper Form - Mail to:
WorldTrips
Box No. 2005
Farmington Hills, MI 48333-2005

Online Form – Go to:
https://service.worldtrips.com/
Email:
service@worldtrips.com

QUESTIONS OR GUIDANCE

For questions or guidance in filling out this form, please visit https://www.worldtrips.com/claims-resource-center. You can also call us toll-free at **800-605-2282** within the U.S. or collect at **1-317-262-2132** from anywhere else in the world. When calling, please mention the country and area code that you are calling from.

PART A: CLAIMANT INFORMATION

1A. Claimant's Full Name:		**2A. Gender:**	**3A. Date of Birth (MM/DD/YY):**	
4A. Current Mailing Address:				
5A. City:		**6A. State:**	**7A. Postal Code:**	**8A. Country:**
9A. Home Telephone:	**10A. Work Telephone:**	**11A. Email Address:**		
IMPORTANT: We CANNOT process your claim without the correct ID Number. You can locate this number on your Policy Document or Policy ID Card.			**12A. ID or Certificate Number**	
13A. Citizenship:	**14A. Home Country*:**	**15A. Countries Visited:** (WorldTrips may request a copy of your passport.)		

16A. Are you a full-time student? ☐ **Yes** ☐ **No** - **If YES, please provide the following:**

Name of School:
Address of School:

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PART A: CLAIMANT INFORMATION (Continued)

City:	State:	Postal Code:	Country:

IMPORTANT – Be Sure to Attach:

- **If in the United States, a copy of your valid, education-related visa (F-1 or J-1 visa, OPT, etc.) and/or valid I-20 / DS2019.**
- **Proof of your full-time student status (please disregard this item only if you are submitting a copy of a valid F-1, including OPT, or J-1 visa).**

17A. Are you employed? ☐ **Yes** ☐ **No - If YES, please provide the name and address of employer:**

Name of Employer:			
Address of Employer:			
City:	State:	Postal Code:	Country:

NOTE: If you are a student, please see the important note in section 16A.

18A. Do you have any other coverage (medical, indemnity, or liability), other than that provided by WorldTrips, which might help cover hospital and medical expenses? ☐ **Yes** ☐ **No If YES, please provide the following and a copy of the declaration page:**

Name of Insurance Company:	Policy Holder:	Policy Number:	Effective Date (MM/DD/YY):
Address:			
City:	State:	Postal Code:	Country:
Is this group insurance? ☐ Yes ☐ No	Is this insurance obtained through a university or school that you attend? ☐ Yes ☐ No		

**Home Country is where you principally reside & receive regular mail.*

PART B: MEDICAL INFORMATION

YOUR PRIMARY CARE PHYSICIAN

For our records, please provide your family or primary care physician information (even if not consulted for this claim):

1B. Physician's Name:		2B. Physician's Telephone:	
3B. Physician's Address:			
4B. City:	5B. State:	6B. Postal Code:	7B. Country:

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PART B: MEDICAL INFORMATION (Continued)

ILLNESS OR INJURY

8B. How did the illness or injury begin? State fully all symptoms and describe in detail from the beginning, including first date of onset.

9B. If due to an accident, please provide the following details:

Accident Date (MM/DD/YY):	Accident Time:	Accident Location:
Brief Summary of the Accident Details:		

10B. If an accident, was it involving a motorized vehicle? ☐ Yes ☐ No

If YES, please include a copy of the police report and complete the following regarding the insurance of the vehicle(s) involved:

Insurance Company Name	Insurance Company Address	Insurance Company Telephone

11B. If an accident and you have hired legal counsel, please provide:

Case Number:	Attorney Name:	Attorney Telephone:
Attorney Address:		

City:	State:	Postal Code:	Country:

12B. Have you ever had or been treated for the same kind of illness or injury? ☐ Yes ☐ No If YES, please provide the following:

Date Treated (MM/DD/YY):	Attending Physician's Name:	Attending Physician's Telephone:
Attending Physician's Address:		

City:	State:	Postal Code:	Country:

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PART B: MEDICAL INFORMATION (Continued)

13B. Have you had any ailments, diseases, illnesses, conditions, or injuries, or have you taken any medications during the last five years?

☐ **Yes** ☐ **No** **If YES, please provide the following:**

Name / Description of Condition or Medication	Date(s) (MM/DD/YY)	Physician Name	Physician Address	Physician Telephone

If additional lines are needed, continue answers in the section titled "Supplement A – Illness or Injury."

14B. Was the incident related to your employment? ☐ **Yes** ☐ **No** **If YES, please provide the following:**

Employer Name:			**Employer Telephone:**
Employer Address:			
City:	**State:**	**Postal Code:**	**Country:**

PART C: MEDICAL RECORD AUTHORIZATION

1C. VERIFICATION

I verify that all information contained in this form is true, correct, and complete to the best of my knowledge. I authorize any licensed doctor, practitioner of the healing arts, hospital, clinic, health-related facility, pharmacy, government agency, insurance company, group policyholder, employee, or benefit plan administrator having information as to the care, advice, treatment, diagnosis, or prognosis of any physical or mental condition, or the financial or employment status of the insured named below, to provide this information to WorldTrips. I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be as valid as the original. This authorization is valid for twelve months from the date signed:

_____

Claimant's Signature

_____ _____

Print Name **Date (MM/DD/YY)**

2C. ASSIGNMENT OF BENEFITS AUTHORIZATION

I authorize payment of medical benefits to the doctor or other supplier of services submitting the attached bills.

_____ _____

Signature of Insured **Date (MM/DD/YY)**

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NOTE: If payment for these claims has already been made, please provide all receipts for payments. If you would like to be reimbursed via ACH or wire (instead of a check), or if you would like WorldTrips to pay a third party other than yourself, please complete the appropriate form located in "Supplement C – Payment Forms."

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SUPPLEMENT A – ILLNESS OR INJURY

Use the additional form fields below if needed from question **13B**.

Name / Description of Condition or Medication	Date(s) (MM/DD/YY)	Physician Name	Physician Address	Physician Telephone

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SUPPLEMENT B – PAYMENT FORMS

Use the form below as it pertains to "2C. Assignment of Benefits Authorization." *If you would like to be paid via ACH or wire, complete the "Authorization Agreement Form – Wire Payments" section below.*

AUTHORIZATION AGREEMENT FORM - WIRE PAYMENTS

The insured hereby authorizes WORLDTRIPS to initiate credit entries to the account indicated below at the depository financial institution named below. It is also acknowledged that the origination of WIRE transactions to the specified account must comply with the provisions of U.S. law. **Additionally, WORLDTRIPS reserves the right to limit wires to a $250 minimum.**

1. Beneficiary Name:	**2. Home Telephone** (If Applicable)**:**	**3. Email Address** (If Applicable):	
4. Beneficiary Address:			
5. City:	**6. State:**	**7. Postal Code:**	**8. Country:**
Bank Information			
9. Bank Name:	**10. Beneficiary Account Number or IBAN Number:**	**11. Swift Code or Routing Number:**	
12. Bank Branch & Address:			
13. City:	**14. State:**	**15. Postal Code:**	**16. Country:**
Intermediary Bank Information (If Applicable)			
9. Bank Name:	**10. Account Number or IBAN Number:**	**11. Swift Code:**	
12. Bank Branch & Address:			
13. City:	**14. State:**	**15. Postal Code:**	**16. Country:**

_____ _____ _____

Printed Name of Insured Person **Insured Signature** **Date (MM/DD/YY)**

THIRD PARTY FORM

Please complete this section if payment is to be made to a third party other than the insured or medical provider. Please provide the name and details to whom any benefit should be paid and sign to indicate authorization for us to reimburse this person.

1. Name:
2. Address:

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3. City:	4. State:	5. Postal Code:	6. Country:

I authorize payment of medical benefits to the third party listed above.

_____

Printed Name of Party Completing Form

_____ _____

Signature **Date (MM/DD/YY)**

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SUPPLEMENT C – NON-U.S. CLAIM ITEMIZATION FORM

This form is required for medical charges incurred **outside** the U.S. If you are filing a claim for medical charges incurred within the U.S., please skip Supplement C.

Date of Service (MM/DD/YY)	Provider	Diagnosis	Translation of Services	Monetary Units	Country	Amount Charged

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SUPPLEMENT D – AUTHORIZATION FORM FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

YOU MUST FILL OUT THE SECTIONS BELOW IF YOU WISH TO AUTHORIZE WORDLTRIPS TO DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO ANOTHER PARTY.

This form authorizes WorldTrips to use and/or disclose your protected health information ("PHI") to individuals you specify. For the purpose of this form, PHI shall be considered protected health information, which is individually identifiable health information received from or maintained by WorldTrips. Without a completed and signed authorization form, federal law prohibits WorldTrips from releasing your PHI to your spouse, parent, adult children, or other family members or close personal friends unless you are present at the time of disclosure. *No benefits will be withheld from you if you refuse to sign this form.*

SECTION A: Individual Authorizing Use and/or Disclosure

Insured Name: _____

Policy/Certificate Number: _____

SECTION B: The Use and/or Disclosure Being Authorized

The information to be used and/or disclosed is:

___ Claim & payment data ___ Eligibility and enrollment

___ Bills, requests for payment ___ Payments or coverage under the policy / certificate

___ Other (please specify) _____

Purpose of this use and/or disclosure:

____ At my request

____ Other (please specify) _____

Persons this information may be disclosed to:

1. _____ Relationship to Insured _____
2. _____ Relationship to Insured _____
3. _____ Relationship to Insured _____
4. _____ Relationship to Insured _____

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SECTION C: Expiration

This authorization will expire (complete one):

____ On _____/_____/_____ (MM/DD/YY)

____ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized): _____

SECTION D: Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time by notifying WorldTrips in writing, but the revocation will not have any effect on any actions that WorldTrips took before we received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive health care benefits to which I am otherwise entitled.
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity and I understand that the information may no longer be protected by the Health Insurance Portability Accountability Act of 1996 (also known as HIPAA).

POLICYHOLDER'S SIGNATURE

I, having had the full opportunity to read and consider the contents of this authorization, hereby authorize WorldTrips to use and/or disclose my protected health information as indicated above.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the policyholder / certificate holder, complete the following:

Personal Representative's Name: _____

Relationship to Policyholder / Certificate Holder for Whom This Authorization Applies: _____

Note: If requested, you must provide valid and current proof of your legal relationship as a personal representative.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

A copy of this form may be used as if it were an original.