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

Email: Gallagher@hsri.com

HSR
Health Special Risk, Inc.

HSR Plaza
8400 Belleview Drive, Suite 150
Plano, Texas 75025
Telephone (972) 512-5600, Fax (972) 512-5820
Toll Free 1-866-523-3183

Policy Name

Boston University

Policy Number

GLM N19010338

Underwritten by ACE American Insurance Company

TO BE COMPLETED BY TRAVELER

School Name: Boston University Policy # GLM N19010338

1. Traveler Name _____ ID Number X X - X X - X X 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 N/A

Relationship N/A Date of Birth X X - X X - X X

8. Describe the conditions that caused this claim: (Select one and attach additional pages if needed): ☐ Illness ☐ Injury ☐ Death

_____ Date of Initial Treatment ____-____-____

9. Has the patient been treated for the above condition(s) in the last 6 months? ☐ Yes ☐ No

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? _____

What country did the accident occur in? _____

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 any 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.) N/A (Name) N/A (Relationship)

Insurance Co. or Benefit Plan N/A Sponsor or Employer N/A

Insurance Co. Address N/A Sponsor Address N/A

Telephone (____) N/A Plan/Group Number N/A Sponsor Telephone (____) N/A

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.

New York Fraud Warning Notice: 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 material 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.

☐ Issue reimbursement directly to Boston University _____

☐ Issue reimbursement directly to Insured (Proof of Payment must accompany this request)

I authorize medical payments to physician or supplier of service(s) described on any attached/enclosed statements.

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** _____

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 form.