Non-US Claim Form Questionnaire

Part 1 - Please complete all sections below		
This claim is related to (please choose one from the drop down box): Other		
Claimant/Insureds Name:		
Date of Birth (M/D/Y):	☐ **Male** ☐ **Female**	**Home/Cell Phone:**
Mailing Address (Reimbursement checks will be mailed to this address):		
City, Providence:	**Postal Code:**	**Country:**
Email:		
How would like your claim(s) correspondence to be sent (Please check one): MAIL		
Destination Country(ies):		
Citizenship of Claimant:	**Home Country:**	
Full-Time Student: ☐ **Yes** ☐ **No**		
If yes, please provide the name and address of the school:		

Part 2 -If covered by another insurance plan please complete the section below	
Do you have additional Insurance? No	
Name of Primary Insured of other insurance company:	**Date of Birth (M/D/Y):**
Please provide name of other insurance company:	
Policy Number of other insurance plan:	**Group Number of other insurance plan:**

Azimuth Risk Solutions

Non-US Claim Form Questionnaire

Part 3 - Please complete all applicable questions below, although more information may be requested. (If you need additional space, please attach a separate sheet)

1. **What medical Illness, Condition or Injury are you being treated for?**
   Please describe all symptoms.

2. **If Injury related, please describe how the injury occurred? (Specify what activity or sport as well as where you were located at the time of injury)**

3. **When did the first symptom of this Illness, Condition or Injury begin (M/D/Y)?**

4. **Have you ever been treated for this Illness, Condition or Injury before? ☐ Yes ☐ No**
   If yes, please list the treatment dates (M/D/Y) and complete question #4.

5. **List the names and addresses of all the providers you have seen for this Illness, Condition or Injury:**

6. **Did your Injury involve a motor vehicle accident? ☐ Yes ☐ No If yes, please provide the name of all parties involved, insurance carriers and policy numbers, and the date of the accident (M/D/Y):**

7. **Was a police report filed ☐ Yes ☐ No If yes, please submit a copy of the police/accident report with this claim form.**

8. **Is this Illness, Condition or Injury related to a work accident? ☐ Yes ☐ No**
   If yes, have you applied for workers compensation? ☐ Yes ☐ No

Non-US Claim Form Questionnaire

Part 4 - Please complete this section for all services incurred outside of the US. List each service/claim separately. (If you need additional space, please attach a separate sheet)

Illness, Condition or Injury:	Procedure(s), Treatment or Medication(s)	Physician/Facility, Address & Phone #:	Date of service (M/D/Y):	Total Charge Paid:	Currency Paid:

Part 5 - Authorization for Release of Medical Information

In order to process a claim for benefits, I authorize any physician, hospital, or other Medical Provider to release to Azimuth Risk Solutions, or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed two and one-half years from the date signed. I understand I have a right to receive a copy of this authorization.

Signature of Patient/Guardian:_____ **Date:**_____ **(M/D/Y)**

Printed Name of Patient/Guardian:_____ **Date:**_____ **(M/D/Y)**