



# 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 15<sup>th</sup> 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 \_\_\_\_\_  
Signature of Insured Person

X \_\_\_\_\_  
Signature of Patient (if other than insured)

Date: \_\_\_\_\_