# Claim Form

*Please submit this completed Claim form with itemized bills and receipts. A separate Claim Form is needed for each member. Please tape small receipts on a full size sheet of paper. Failure to provide acceptable proof of loss or to complete all sections of this form will result in claim processing delays.*

***This claim is for:*** ☐ Medical ☐ Dental ☐ Maternity ☐ Vision ☐ Wellness

*Please refer to your policy wording to determine the cover available.*

**IMPORTANT NOTE:** ***Please ensure the claim is submitted within 180 days from the date charges are incurred.***

## HOW TO SUBMIT A CLAIM

International Medical Group provides alternative methods of submitting a claim to make it easier for insured persons. Below are several options.

| | |
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| **International Medical Group®, Inc.**<br>Expedite claim submission using https://myimg.imglobal.com or send this form to:<br>Claims Department<br>P.O. Box 88500<br>Indianapolis, Indiana 46208-0500 USA | • Email Submission with copies of your bills and statements from your Medical Practitioner to Caribbean Assurance Brokers Limited: **CABServices@imglobal.com**<br>• For Claim Submission directly to International Medical Group (IMG) or email inquiries: **CustomerCare@imglobal.com**<br>• For Claim Status inquiries from IMG:<br>**Toll Free in USA: 1.800.628.4664**<br>**Direct/Collect: 1.317.655.4500** |

## 1. PRINCIPAL MEMBER INFORMATION *(Must be completed)*

| | | | |
|---|---|---|---|
| Group Name: | | Policy Number: | |
| Member's Full Legal Name: | | | |
| Member's Date of Birth: *(Day, Mo., Yr.)*: | | Member ICHIP Identification Number: | |
| Street Address: | | | |
| City: | State/Province: | Postal/Zip Code: | Country: |
| Member's Telephone Number: | | Mobile Number: | |
| Communications should be sent via E-mail to: | | | |

## 2. PATIENT INFORMATION *(Must be completed)*

| | |
|---|---|
| Patient's Full Name: | |
| Patient's Date of Birth: *(Day, Mo., Yr.)*: | Patient's ICHIP Identification Number: |
| Gender ☐ Male ☐ Female | Relationship ☐ Self ☐ Spouse ☐ Child ☐ Other _____ |

## 3. OTHER INSURANCE COVERAGE *(Must be completed)*

| | |
|---|---|
| Do you hold any other insurance related to the loss? ☐ Yes ☐ No | Other Carrier Name: |
| Other Insurance Policy Number: | Policy Holder Name: |

## 4. MEDICAL INFORMATION *(Please include diagnosis or reason for visit)*

- For charges related to an accidental, details of the accident along with a policy report, death certificate, autopsy, coroner, and/or toxicology reports, etc. must be provided.
- For conditions that have required long term treatments, please provide details of when the symptoms and/or treatment began.
- Claims for prescribed drugs or medication should include a prescription from your GP or medical specialist.

| **Dates of Services** *(month/day/year)* | **Provider's (physician, clinic, hospital, pharmacy, dentist) Name and Address (If the provider's name and address is on receipts, write "See Receipts")** | **Description of Service/Name of Medication/Device (if hospital, state Inpatient, Day Case, or Outpatient)** | **Diagnosis (Reason for visit)** | **Country of Claim** | **Currency of Claim** | **Total Charge** |
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If the claim is for Maternity benefits, please indicate the expected due date of the pregnancy: *(Day, Mo., Yr.)*:

Please advise if your pregnancy is a result of assisted conception/infertility treatment:

For dental claims, please indicate the location of the tooth and ensure itemized breakdown of service is included:

| | |
|---|---|
| Were your injuries caused by an Accident? | ☐ Yes ☐ No |
| If Yes, is it: Motor Vehicle Related? | ☐ Yes ☐ No provide Accident Date _____ Time _____ ☐ AM ☐ PM |
| Work Related? | ☐ Yes ☐ No provide Accident Date _____ Time _____ ☐ AM ☐ PM |

***Please provide accident details on a separate sheet.***

Member's Name / Patient Name

## 5. SUMMARY OF PAYMENT DETAILS *(Must be completed)*

**Reimbursement Election -** Please check one of the following options if you want to:

☐ Receive future payments using the method provided below
☐ Use the payment method provided below for this claim only
☐ Use the payment method that we already have on file for you

**Payment Method**

Please select your preferred reimbursement method*: ☐ Bank Transfer ☐ Cheque
(If no selection is made, the default method is cheque issued in the member's name).
*Cheques are only payable in US dollars. For wire transfer, we will require a wire transfer form be completed and returned.
Payee Name _____ Specify if: ☐ Member ☐ Provider
Claim Settlement Address (if different to **Section 1**):

_____
Street

_____
City State/Province Country

**If you have selected Bank Transfer as your preferred payment method, the following information is required:**

Bank Account Holder Name (as per Bank Statement) _____
Bank Account Number _____ Sort Code/Branch Code _____
IBAN Code* _____ Swift/BIC Code _____
IFSC/ABA/US Routing Code _____
Bank Name _____
Bank Address (including Country) _____
Bank Telephone Number (include Country Code) _____
*The IBAN is mandatory for all UAE bank transfer claim payment transactions. If using bank accounts in the UAE, this must be supplied.

**The most efficient method of receiving your benefits reimbursement is via Bank Transfer. Please check with your bank for help with providing the appropriate information to International Medical Group.**

## 6. AUTHORIZATION *(Must be completed)*

The undersigned understands a valid authorization is required for any use or disclosure of PHI not required or otherwise permitted without authorization by applicable privacy and confidentiality laws. The undersigned authorizes any health plan, health care provider, health care professional, MIB, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency, employer, benefit plan, or any other organization or person that has provided care, advice, diagnosis, payment, treatment, or services to the insured or on the insured's behalf, has any records or knowledge of the insured's health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the insured, and any non-medical information about the insured, to disclose the insured's entire medical record, file, history, medications, and any other information concerning the insured and to give any and all such information to the insured's agent of record and authorized representatives of the insurer, IMG, and their affiliates, and subsidiaries. This information will be used to evaluate claims for benefits. Individuals have the right to refuse to sign the authorization without negative consequences to treatment or plan enrollment, except IMG will not be able to administer claims, determine benefit eligibility, or issue payments. The authorization is valid for the term of the insurance contract or plan under which a claim has been submitted. The undersigned understands that the insured has the right to receive a copy of this authorization upon request and revoke the authorization at any time in a written communication to IMG. A copy of this shall be as valid as the original. The undersigned acknowledges and understands there is the potential for the information to be subject to redisclosure by the recipient and to no longer be protected by applicable privacy and confidentiality laws. The undersigned represents and warrants information or documents provided to IMG by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees: 1) any insurance coverage or benefit is contingent upon any statement made to IMG as being complete and correct, and 2) benefits under any contract will be paid only if IMG decides the applicant is entitled to them.

| **Member's Signature** *(If patient is under 18 years of age, Parent or Guardian must sign)* | **Date:** *(Day, Mo., Yr.)*: |
|---|---|
| | |

## IMPORTANT NOTE

Please note International Medical Group is not responsible for any costs associated with the completion or submission of this form or for any further information/document requested to assess your claim. The submission of this claim form does not automatically guarantee payment of benefits. Please refer to your policy wording which outlines when pre-authorisation is required.

ICHIP Assurance Everywhere