iNext - Accident & Sickness

Claim Form & Claimant's Statement

Nationwide®

PARTICIPANT'S INFORMATION:

School and Program Names:____

Policy Number:____

Name: ____ Date of Birth: ___/____/_____

Home Phone #: (________) ________________________ Cell #: (________) ________________________

Email Address:________________________________ Work Phone: (_____) ________________________

Address:______________________________ City:________________ State:____ Zip Code:__________

Please advise if you wish to be contacted via e-mail or regular mail: ________________________________

TRAVEL INFORMATION:

Date Travel Arrangements were made: _____/_____/_____ Date of initial payment deposit: _____/_____/_____

Scheduled Date of Departure: ____/____/_____ Scheduled Date of Return: ___/____/_____ Destination: ______________

OTHER COVERAGE / AUTHORIZATION:

Do you have any other type of coverage?____

If so, please provide the Company Name and Address:__________________________________

Type of Policy: _____________Policy #: _____________Contact: _____________Phone: (________) ____________

Have you filed a claim with their office at this time?: Yes _____ No ______

If yes, please note their response:____

If not, why not:____

ILLNESS/ACCIDENT STATEMENT:

Name of person having sickness or injury: ______________________________His / Her date of birth: ____/____/____

Date Sickness or Injury began: _____/_____/______ Date First Treated: ____/____/_____

Nature of Sickness or Injury (If Injury, describe accident, including date and place): ______________________________

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____

____

Period of hospitalization: From: ____/____/_____ To: ____/____/_____ Date ended: ____/____/_____

Was there an accident report for this incident? ______ If Yes, please provide a copy.

Was there any previous treatment for this condition? ______________ If Yes, please names of physician and dates of treatment:

____

____

DOCUMENTATION REQUIREMENTS:

Depending upon the circumstance involved in the loss, one or more of the following items may be required to complete the processing of your claim. Please place a check by those items you have attached. We recommend you keep copies of any items submitted with this claim.

- Copies of itemized bills and/or statement from medical providers for services rendered in connection with your claim. These bills and/or statements must include the date of service, the service rendered, the charge for each service, and the diagnosis
- If you have other insurance, we need the final disposition from the primary insurer listing payment or denial of your claim with them (Explanation of Benefit or "EOB").
- Copies of the front and back of your cancelled checks and/or your credit card statements showing your payments for the trip; and a copy of your trip invoice.
- Airline Ticket Stub/Receipt (if applicable)
- Copies of your credit card statements and/or cancelled checks showing your payment for the medical service submitted
- If medical expenses were incurred abroad, attach copies of your passport pages which identify you as the traveler and document your entrance into and exit from the country or countries where medical services were received
- Other (please describe):____

Please advise if you wish to be contacted via e-mail or regular mail____

EXPENSES CLAIMED:

Please provide supporting documentation of the expenses you are claiming in addition to this claim form

Name of Provider	Date Incurred	Amount of Bill	Amount Paid by Other Insurance	Amount Claimed

TOTAL AMOUNT CLAIMED $ _________

I UNDERSTAND that it is illegal to knowingly file a false or fraudulent claim or to knowingly help someone else file one. I have read and understand the Fraud Notices on page 4 of this document.

_____________________________________ _________________________

Signed **Date**

ASSIGNMENT OF BENEFITS:

I hereby ASSIGN all benefits to which I am entitled to school (or facility) named above. I understand that I am responsible for any amount not covered by insurance.

_____________________________________ _________________________

Signed **Date**

Authorization For Release of Medical Information – To be Completed by Patient

In order to process a claim for benefits, **I AUTHORIZE** any physician, hospital, or other Medical Provider to release to the Travel Insurance Claims Administrator, 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.

Date ____________________ **Signature** ____

(Signature of Person Suffering Illness or Injury or legally authorized representative)

MAILING INSTRUCTIONS:

Send this form and any accompanying documentation to:

Attention: Co-ordinated Benefit Plans, LLC
On Behalf of Nationwide Mutual Insurance Company and Affiliated Companies
P.O. Box 26222, Tampa, FL 33623
Or E-mail your information to: NWTravClaims@cbpinsure.com
Questions: 866-723-3063 (direct dial 727-412-7378)

CONSENT TO RECEIVE ALL COMMUNICATIONS ELECTRONICALLY

Please be advised, our preferred method of communication with you is electronically by email. Use of email helps us provide better and faster service. Please provide your consent to this in the area below. We will keep this on file with your claim.

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EXPRESSED CONSENT TO RECEIVE ALL COMMUNICATIONS ELECTRONICALLY:

I AGREE TO RECEIVE ALL MAILINGS AND COMMUNICATIONS ELECTRONICALLY.

I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THE ELECTRONIC DELIVERY*

I ACCEPT ____ (please write in YES OR NO)

Please confirm the preferred Email address in clear print below:

ENTER Email Address Here:

****

***CLICK THE TERMS AND CONDITIONS ABOVE TO REVIEW ONLINE, OR DOWLOAD A COPY BY TYPING THE BELOW URL INTO YOUR INTERNET BROWSER:**

http://policydocuments.tpaproducts.com/EDOD/consent.pdf

FRAUD STATEMENTS – If you reside in the state of:

General: 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 fact material thereto, commits a fraudulent insurance act.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

District of Columbia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New York: 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 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.

California: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Missouri: An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

Pennsylvania: 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 fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."

All Other States: 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 fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.

EFFECTIVE DATE

This Notice is effective May 16, 2014.