



# Claim Form

This Claim Form is to be used only if your provider did not file Claims directly to International Claims Services (ICS) on your behalf. Return this form **along with itemized bills, diagnosis, and receipts** to the address below. ICS must receive Claims within 180 days after first day of treatment.

**COMPLETION OF ALL FIELDS BELOW IS REQUIRED TO PROCESS THIS REIMBURSEMENT REQUEST.**

## SECTION A. PRIMARY INSURED INFORMATION

Name (Last, First, MI):	Employer:	
Policy Number:	Member ID Number:	Email:
Current Resident Address and Country:		Phone Number:

## SECTION B. PATIENT INFORMATION (Please check who this claim is for)

<input type="checkbox"/> Primary Insured <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth: _____ <input type="checkbox"/> Married <input type="checkbox"/> Single Current Country of Residence: _____	<input type="checkbox"/> Dependent Insured: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Male <input type="checkbox"/> Female    Date of Birth: _____ Name: _____ Current Country of Residence: _____
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## SECTION C. CLAIM INFORMATION

Date illness / injury occurred:	Is the claim for Maternity treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe problem, diagnosis, symptom, or complaint:	
Delivery Date: _____	
Doctor's Diagnosis and/or results of your visit:	
Has diagnosis and/or treatment for same condition or related condition been given previously? If so, state dates, results, kind of treatment, prescribed drugs, and name of doctor or facility:	
<b>Was illness or injury due in any way to:</b> a. The patient's occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No b. An automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Any type of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details, including date of accident: _____ _____ _____	<b>Is the patient also covered by:</b> a. Any other group health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Medicare or other Govt. Agency? <input type="checkbox"/> Yes <input type="checkbox"/> No c. No-Fault auto carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide name and address of other source: _____ _____ _____

## DOCTOR / FACILITY INFORMATION

Doctor / Facility / Provider Name:	Phone Number:
Address / Country:	
Provider email address (if available):	





SECTION C. CLAIM INFORMATION (continued)

The following treatments and/or prescribed drugs were provided and the charges for each are listed below.

ATTACH RECEIPTS IN ORDER TO RECEIVE PAYMENT

Table with 4 columns: Date of Service (Day / Month / Year), Description of each service and/or prescribed drug, Cost, Currency. Includes rows for patient and provider totals.

SECTION D. PAYMENT INFORMATION

Please make payment to: [ ] Member [ ] Provider (Payment by check)

PAYMENT TYPE (Please make payment as marked below):

[ ] Member Address in Section A

[ ] Other Mailing Address:

[ ] Send by Electronic Direct Deposit (Bank must be located in US), or Wire Transfer (Banks located outside of US)

Name of Bank: \_\_\_\_\_

Name on Account: \_\_\_\_\_

Account # / IBAN: \_\_\_\_\_

Routing Number (ABA #) for electronic transfer: \_\_\_\_\_

SWIFT code for Wire Transfers: \_\_\_\_\_

Address of Bank for Wire Transfers: \_\_\_\_\_

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

The above answers are true and correct to the best of my knowledge. I authorize any physician, medical institution, pharmacy, insurance company, employer, labor union, or association to release information to Global Benefits Group as required to properly pay all benefits, if any due to me, my spouse, or any other dependents. A photocopy of this authorization shall be considered effective and valid as the original.

I declare that I have received, understood and accepted the Privacy Notice in connection with the processing of my personal data by this Application form.

Signature

Date

Submit Claims to International Claims Services

- Online Claims Submission available at www.gbg.com
• Mail to: 26000 Towne Centre Drive, Suite 130 Foothill Ranch, CA 92610 USA
• Fax to: +1 949-271-2330

Contact our Customer Service Department for Claims Inquires:

- Email: claims@gbg.com
• Call: USA Toll Free 1-877-916-7920
Outside of USA +1 949-916-7941

