TRAVEL GUARD
CHARTIS

HSR
Health Special Risk, Inc.

Oregon University System Study Abroad Accident & Sickness Plan

1. Please fully complete this form
2. Attach itemized bills
3. Mail to: *Health Special Risk, Inc.*

Email: GKstudyabroad@hsri.com

HSR Plaza
4100 Medical Parkway
Carrollton, Texas 75007
Telephone (972) 512-5600, Fax (972) 512-5820
Toll Free1-866-523-3183

Travel Assistance and Medical Emergency
US or Canada Toll Free
(877) 244-6871
Outside US or Canada Call Collect
(713) 260-5592

TO BE COMPLETED BY STUDENT

School Name: ______________________________ Policy #______________________

1. Student Name ______________________ Insurance ID Number _______-_____-________ Date of Birth_____-______-______
2. Mailing Address ____
   Number Street City State Zip
3. Permanent Address ____
   Number Street City State Zip
4. Best Contact Phone Number, Including Area Code (_____) ________________ Email: ______________________
5. Gender ☐ Male ☐ Female 6. Patient Status ☐ Single ☐ Married
7. Is this claim for a dependent? ☐ Yes ☐ No If yes, give name ______________________

   Relationship______________________ Date of Birth ________-______-________
8. Describe the conditions that caused this claim: (Select one and attach additional pages if needed): ☐ Illness ☐ Injury ☐ Death

   ____Date of Initial Treatment _______-______-_______
9. Has the patient been treated for the above condition(s) in the last 6 months? ☐ Yes ☐ No

   If yes, give condition(s) treated for and date(s) of treatment______________________
10. Is this claim the result of an accident? ☐ Yes ☐ No If yes, give date of accident _______-______-_______

    Where did the accident occur? ____

    How did the accident happen? ____
11. Is this claim the result of a work related injury? ☐ Yes ☐ No
12. Is the patient covered for benefits (other than this policy) by any of the following?

    ☐ Yes ☐ No Any individual, Blanket or Short Term Medical Insurance?

    ☐ Yes ☐ No Group Health Benefits of an kind through an employer, spouse's employer or parent's employer?

    ☐ Yes ☐ No Coverage of medical care expenses provided through any Federal, State, Provincial, or other Government Agency?

    If any of the above apply, please complete the following:

    Through whom is your coverage provided? (i.e. parent, spouse, etc.) ______________________
    Name Relationship

    Insurance Co. or Benefit Plan ______________________ Sponsor or Employer ______________________

    Insurance Co. Address ______________________ Sponsor Address ______________________

    Telephone (_____) ______________ Plan/Group Number ____________ Sponsor Telephone (_____)______________

I know it is a crime to fill out this form with facts I know are false or leave out facts I know are important. I certify that the information furnished by me in support of this claim is true and correct. I further acknowledge that I am legally obligated to pay for all medical expenses submitted for this claim in the absence of this health insurance plan.

☐ Issue reimbursement directly to Participating Organization ______________________________

☐ Issue reimbursement directly to Insured (please submit proof of payment)

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

SIGNATURE ____ **DATE** ____________________

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE ____ **DATE** ____________________

PLEASE SEE CLAIM FILING INSTRUCTIONS ON THE REVERSE SIDE

Listed below are important instructions and comments about filing a claim.

YOUR CLAIM FORM

1. This claim form should be fully completed and submitted within 90 days from the date of injury. Be sure to sign the line for authorization, so that ***HSR*** and the doctors/hospital may communicate concerning your claim. **Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.**
2. Only one claim form for each accident needs to be submitted.
3. Once completed, make a photocopy for your records, and mail to the address shown below.
4. DO NOT assume that anyone else will mail this claim form to ***HSR*** for you.

YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills.
2. If you have already been to the doctor/hospital and did not know about this coverage, then please send all of the itemized bills to ***HSR*** at the address shown below.
3. The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for and the specific itemized charges incurred.
4. If this information is not on the bill when you send this in we will have to contact the doctor/hospital which will delay the review of your claim. "Balance Due" statements do not contain sufficient information to complete your claim.

PRIMARY INSURANCE

1. This policy provides coverage on a primary basis. If you have any other insurance coverage you need to send the bills to ***HSR*** first.
2. ***HSR*** will process benefits on a primary basis, after which you may submit a claim to your secondary carrier.
3. Your secondary insurance will require a copy of our Explanation of Benefits (EOB) which you will receive from ***HSR*** letting you know what was paid or denied, and the reason(s) why.
4. Your secondary carrier will not be able to consider your claim without this information.

If you have any questions, please contact Customer Service at (800) 328-1114. They are available from 8:00 a.m. thru 5:00 p.m., Monday – Friday. You may also forward any documents by fax to (972) 512-5820.

Health Special Risk, Inc.
4100 Medical Parkway
Carrollton, TX 75007