PATIENT AUTHORIZATION FORM

Name of Patient: _____ Date of Birth:_____
SS#:_____ Purpose of release: TRAVEL INSURANCE CLAIM

DOCTORS AND/OR MEDICAL FACILITIES AUTHORIZED TO RELEASE MY HEALTH INFORMATION:

Name	Address	Telephone	Fax	Dates Treated

You are authorized to release any health information that may have bearing on the request for benefits submitted in conjunction with the travel protection plan to: Europ Assistance USA and Insurance Services, its affiliates, underwriters, reinsurers, and any agent expressly acting on behalf of Europ Assistance USA and Insurance Services. Additionally, if there is potential fraudulent activity you release medical information related to the identification and prevention of the fraudulent activity to the underwriters, insurance support organizations, fraud information clearinghouses and designated service providers assisting in the processing of the claim.

SEND TO: Europ Assistance Insurance Services
Attn: Claims Department, 4330 East West Hwy - Suite 1000, Bethesda MD 20814
FAX: (301) 907-7417. OPS@europassistance-usa.com

Information to be released (Please circle all that apply): Physician Dictation, Physical and/or Occupational Therapy Records, Office Notes, Lab Reports, Entire Record,
Other:_____

I UNDERSTAND THE FOLLOWING:

• If applicable, HIV/AIDS, genetic testing, abuse, drugs/alcohol and/or mental health records will be included in the health information that is released.
• I may revoke this authorization to the health information management department in writing. My revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless revoked, this authorization will expire in six months.
• I may inspect or copy the information to be used or disclosed, as provided in CFR164.524. Any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I am entitled to a copy of this authorization. A facsimile or photocopy can be treated as the original.
• THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.
• My treatment, payment, or enrollment may not be conditioned on signing this authorization. If I refuse to sign this authorization; benefits may not be paid under the travel protection plan if additional health information is needed to determine my eligibility for benefits.

_____
Signature of patient or authorized person Date:

_____
Relationship/Reason patient is unable to sign

AFFIDAVIT OF NO INSURANCE

I/we, _____ hereby declare under penalty of perjury that I/we do not have any other valid and collectible insurance or indemnity coverage that was in effect during the covered trip.

_____ _____
(Signature) (Date)

_____ _____
(Signature) (Date)

_____ _____
(Witness signature) (Date)

INSTRUCTIONS:
1. Complete form in its entirety. If any questions do not apply, please mark "N/A" in the field.
2. Attach original itemized medical bills and receipts.
3. Read the applicable fraud statement and the Authorization.
4. Sign the claim form below.
5. Mail to:

Europ Assistance USA
Claims Department
4330 East West Highway
Suite 1000
Bethesda, MD 20814
OPS@europassistance-usa.com

GENERAL INFORMATION

GROUP POLICYHOLDER/EMPLOYER NAME: Rotary International – SRPO-50609-660		Name of Insured Employee/Participant:
Name of Claimant (if different from above):	Relationship of Claimant to Employee/Participant:	Date of Birth of Claimant:
Mailing address:	Phone number:	Email address:

INFORMATION ABOUT THE ILLNESS/ACCIDENT

Date that Sickness/Accident Occurred:	Please describe reason for medical visit and diagnosis:
Was the incident reported? If yes, please provide a copy of the report.	

City, State and Country where the accident or sickness occurred:

List all Doctors and Medical Facilities that Provided Treatment:

Doctor Medical Facility:	Address:	Phone Number:	Facsimile Number:	Date visited

Was claimant hospitalized for the illness or sickness?:

☐ Yes ☐ No

If yes, please provide dates of confinement:

INFORMATION ABOUT THE TRIP

Was the Insured on an authorized trip at the time of the accident/illness? ☐ Yes ☐ No	Dates and location(s) of trip:	Purpose of the trip: Policyholder confirmation of trip received? ☐Yes ☐No. If yes, please provide the name, title and phone number of approver:

OTHER INSURANCE INFORMATION

Did you have other health insurance, medical insurance or dental insurance? ☐Yes ☐No If yes, what is the status of the claim and phone number of the providers?

Did you file a workers' compensation claim? ☐Yes ☐No If yes, what is the status of the claim and phone number of the insurance company?

Please provide the name of your health insurance compan(ies)	Policyholder(s) and Policy Number(s):
Name of Primary Member(s) and relationship to claimant:	Member ID(s):

Have you submitted a claim for benefits with the above health insurance companies? ☐Yes ☐No
If yes, please submit copies of all explanation of benefits from the health insurance companies.

DESCRIPTION OF MEDICAL EXPENSES AND AMOUNT CLAIMED

Please list all medical expenses incurred for a sickness or injury. Please enclose copies of medical bills, reports and explanation of benefits from your primary or supplemental health, medical or dental insurer:

Name of Doctor or Hospital	Date Treated	Amount of Bill	Amount Paid by Other Insurance	Amount Claimed

AUTHORIZATION

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the deceased or insured's occupation, finances and health including protected health information, individually identifiable health information, summary health information, psychotherapy notes, mental health, HIV and alcohol/drug records to release all such records in their entirety to AXIS Insurance Company, and any affiliate of any one or more of these companies (collectively and severally, the "Company"). I understand that I may receive a copy of this authorization, and that this authorization is valid for the entire duration of this claim, and that I may revoke this authorization at any time be sending a request in writing to the Company. I understand that it may be necessary for the Company to provide such information or summaries thereof to the employer, regulatory state agency, or Workers' Compensation carrier. I understand that by signing this form I may be authorizing the use and disclosure of my confidential protected health information to AXIS Insurance Company.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNATURE OF PERSON COMPLETING THIS FORM	DATE

FRAUD STATEMENTS

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.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Maryland, West Virginia: 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Delaware, Idaho, Indiana: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine: 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.

Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another person files a 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 the person to criminal and civil penalties.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada: 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 state or federal law, or both, and may be subject to civil penalties.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in section 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: 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 civil fines and criminal penalties.

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 foe each such violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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.

Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: 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.