CLAIMANT'S STATEMENT AND AUTHORIZATION

(See reverse side for Directions for Submitting a Claim)

MULTINATIONAL UNDERWRITERS, INC.
P.O. Box 863
Indianapolis, Indiana 46206

PART A: Complete for all claims. **All Checks and Correspondence Will Be Sent To The Address Below**				
Insured Name:		Patient Name:		
Sex:	Birthdate:	Sex:	Birthdate:	
Street Address:		City:		Postal Code:
State:		Country:		
Home Telephone:	Work Telephone:	Fax Number:	E-mail address:	
Group Number:		Certificate Number:		

1. Citizenship of Patient: _____ Home Country of Patient: _____
   (Country where patient principally resides and receives regular mail)
   Country Visited: _____
   (Note: MNU may request a copy of your passport)
2. Is the Patient: A full-time Student? ☐ Yes ☐ No If yes, please provide the name and address of school:_____
3. Is the Patient: Employed? ☐ Yes ☐ No If yes, please provide the name and address of employer:_____
4. Do you or any family members have other coverage (medical, indemnity or liability) which might help cover hospital and medical expenses? ☐ Yes ☐ No If yes, please provide the following:

Name of Company:	Address:
Policyholder:	Policy Number:
Is this group insurance? ☐ Yes ☐ No	

PART B: Complete for new claims. If you need additional space, please attach additional sheets.

1. How did the condition begin? State fully all symptoms and describe the condition in detail from the beginning:

2. When did the first symptoms of this condition begin. State the exact date, if possible:
   (In the event of an accident – How, when and where did the accident happen?)

3. Have you ever had or been treated for the same kind of illness or injury? ☐ Yes ☐ No If Yes, when?
   Name, address and telephone number of attending physician:

4. Name, address and telephone number of family physician (even if not consulted):

5. What ailments, diseases, illnesses, conditions or injuries have you had during the last five years? Please provide name and/or description of each condition, dates involved, and the name, address and telephone numbers of attending physicians:

6. Is the condition the result of an accident or illness:
   a.) Related to employment? □ Yes □ No If yes, are you applying for Workers Compensation benefits? □ Yes □ No
   b.) Involving a motor vehicle? □ Yes □ No If yes, list the names of involved parties, insurance carriers and policy numbers:
   Was a police report filed? □ Yes □ No If yes, with what agency? Enclose a copy of the police report.

PART C: Complete for all claims.

I verify that all information contained in this form is true, correct and complete to the best of my knowledge. I authorize any licensed doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial or employment status of the insured named below, to provide this information to MultiNational Underwriters, Inc. I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be as valid as the original. This authorization is valid for twelve months from the date signed:

Signature of Insured:	
Print Name:	Date:

Signature of Patient:	
Print Name:	Date:

AUTHORIZATION: I authorize payment of medical benefits to the doctor or other supplier of services submitting the attached bills.

Signature of Insured:	Date:

DIRECTIONS FOR SUBMITTING A CLAIM

1. If this is a new claim, complete ALL PARTS of this form.

2. If this is a continuing claim, complete Parts A and C only.

3. Attach all original itemized bills for services and supplies. Please verify that the documents indicate your name, date of service, diagnosis and the charge for each service.

4. Mail to: **MultiNational Underwriters, Inc.**
P.O. Box 863
Indianapolis, Indiana 46206

5. If you have any questions, call 1-800-605-2282. If calling from outside the US, call collect to (317)262-2132.

INDIANA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.