KLAIS & COMPANY, INC.
BENEFIT CONSULTANTS & ADMINISTRATORS
1867 WEST MARKET STREET
AKRON, OH 44313-6977
Tele: 330.867.8443 ● 800.331.1096 ● fax: 330.867.0827

International Travel Claim Form (Other Coverage, Pre-existing Condition & Accident Details)

In order to process your claim you must complete all of the information requested on this claim form and submit this form along with an itemized bill, which should be translated into English and the amount paid (in U.S. dollars) to Klais & Company, Inc. at the address above. Please note that you may be responsible for payment to the provider in which case eligible expenses will be reimbursed directly to the Insured.

——————————————————————TO BE COMPLETED BY STUDENT——————————————————————

1. School Name: _____ Policy No: _____
2. Insured Student _____ Member ID: _____
3. Foreign Address: _____
4. Domestic Address: _____
5. Patient Status: ☐ Male ☐ Female ☐ Single ☐ Married _____

   Is this claim for a dependent? ☐ Yes ☐ No If yes, give name: _____

   Relationship: _____ Date of Birth: _____ / _____ / _____

ACCIDENT CLAIM INFORMATION

6. Is this claim the result of an accident? ☐ Yes ☐ No If yes, give date of accident: _____ / _____ / _____ Time of Accident: _____
7. Is this claim the result of a work-related injury? ☐ Yes ☐ No

   Is this claim the result of an auto accident? ☐ Yes ☐ No
8. Where did the accident occur? _____

   How did the accident happen? _____

PRE-EXISTING CONDITION INFORMATION

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. Name of Physician: _____ Date of Initial Service _____ / _____ / _____
11. Description of Illness: _____

OTHER COVERAGE INFORMATION

12. Is patient covered for benefits by any Group Health, Employer, Union, Welfare Plan or Parent Health Plan? ☐ Yes ☐ No

    Other coverage provided through: Name of Person _____ Relationship _____

    If answered "yes" please complete the following:

    Insurance Co. or Benefit Plan _____ Employer or Sponsor _____

    Address _____ Address _____

    Telephone: _____ Telephone _____

    Policy # _____ Please include a photocopy of other plan identification card, if available
13. I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacist to release any information requested with respect to this claim.

If at any time other information received indicates that other coverage is in force, we will pend all claims processing, until further investigation is completed.

It is unlawful to knowingly provide false, incomplete or misleading facts or information regarding a claim for the purpose of defrauding or attempting to defraud to receive benefits. Penalties may include imprisonment, fines, denial of benefits and/or civil damages.
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 loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of Insured Student _____ Date _____ 20 _____

Patient's or Authorized Person's Signature _____ Date _____ 20 _____