

Insurance Company of the State of PA  
C/O MCA Administrators, Inc  
P.O. Box 6540  
Harrisburg, Pa 17112  
1-800-427-9308

**PROOF OF LOSS**

**NAME OF GROUP:** UNITED WORK & TRAVEL INC.  
A Division of American Pool Enterprises, Inc.

**POLICY NUMBER:** GLB9124045

**ACCIDENT AND SICKNESS CLAIM FORM/ GLOBAL**

**INSTRUCTIONS:**

- 1.) This form is to be used when filing a claim for reimbursement of Medical Expenses.
  - 2.) Section A must be completed by the Insured in full.
  - 3.) One of the following must be provided:
    - Section B Fully Completed by the Attending Physician, or
    - Fully Itemized Bills showing Claimant's Name, Nature of Illness/Injury, Description and Charge for each service provided.
  - 4.) This form must be signed and dated in all applicable sections.
  - 5.) This form and all attached bills must be submitted to the address indicated above.
- The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

**SECTION A**

Coverage Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Coverage Termination Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Certificate Number \_\_\_\_  
(If applicable)

Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_

1.) Name of Claimant: \_\_\_\_\_ Claimant's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female  
(PLEASE PRINT)

2.) Current Residence Address: \_\_\_\_\_

3.) Date of arrival in U.S.: \_\_\_\_/\_\_\_\_/\_\_\_\_ Daytime phone number: ( ) \_\_\_\_\_

4.) Permanent Address (In Home Country): \_\_\_\_\_

5.) If injury, give date injury occurred and details of the injury/accident: \_\_\_\_\_

6.) If Illness, advise when and where symptoms first occurred: Country \_\_\_\_\_ Date \_\_\_\_\_  
Please indicate nature of the illness and/or describe your symptoms: \_\_\_\_\_

7.) Have you been treated for this illness or injury prior to the effective date of this insurance? \_\_\_\_\_  
If yes, provide name and address of the treating Physician(s) and date(s) first consulted.

9.) Provide Name and Address of your Regular Physician in your Home Country: \_\_\_\_\_

10.) Were you taking any medications prior to the effective date of this insurance? \_\_\_\_\_ If yes, please provide the following:  
Drug Name: \_\_\_\_\_ Drug Name: \_\_\_\_\_ Drug Name: \_\_\_\_\_  
Prescribed for: \_\_\_\_\_ Prescribed for: \_\_\_\_\_ Prescribed for: \_\_\_\_\_  
Physician Name: \_\_\_\_\_ Physician Name: \_\_\_\_\_ Physician Name: \_\_\_\_\_  
Date 1<sup>st</sup> Prescribed: \_\_\_\_\_ Date 1<sup>st</sup> Prescribed: \_\_\_\_\_ Date 1<sup>st</sup> Prescribed: \_\_\_\_\_

11.) Do you have other health insurance? Yes \_\_\_\_ No \_\_\_\_ If yes, please provide the name, address and policy number of the Insurance: \_\_\_\_\_

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

**AUTHORIZATION and ASSIGNMENT OF BENEFITS**

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I authorize payment of medical benefits to the physician or supplier for service performed.  YES  NO

**Optional Limited Assignment**

I hereby make a limited assignment to \_\_\_\_\_ (my "Assignee") of the right to receive the benefits due for those covered medical expenses incurred by me and actually paid directly to the provider of those services by my Assignee. I understand that the Company bears no responsibility or liability for the validity or effect of this assignment or for any payments made by the Company prior to receipt of satisfactory proof of payment by the Assignee. I hereby specifically release, and agree to indemnify, the Company from any and all liability incurred for any such payments made.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

