HSR
Health Special Risk, Inc.

For Claim Inquiry Call
1-800-328-1114

HEALTHEXTRAS

BLANKET TRAVEL ACCIDENT/SICKNESS CLAIM FORM

1. Please answer **all** questions listed below fully and completely.
2. File separate form for family member, if applicable.
3. An EXPLANATION OF BENEFITS (EOB) from your Comprehensive Major Medical Plan **must** be attached to this claim form (if applicable), in order to process your claim.
4. Attach copies of all medical bills indicating date(s) of service, diagnosis and place of service.

STATEMENT OF ELIGIBLE PERSON

1. Your Name:	Date of Birth:	Male ☐ Female ☐	Certificate #:	Social Security #:
Name of person suffering injury or sickness:				
His/Her Relationship to you:				
2. Your Address: (Number and Street)	City	State	Zip Code	
3. Daytime Telephone Number:				
4. Name of Spouse:				
5. Describe how the accident/sickness occurred and the nature:				
Date of the accident or beginning of sickness:				
(a) Where did the accident/sickness happen?				
(b) Number of miles from your home:				
(c) Scheduled Departure Date:	Scheduled Return Date:			
6. Was this accident/sickness the result of your employment?			☐ Yes	☐ No
Will you file for Workers' Compensation?			☐ Yes	☐ No
7. Name and Address of Physician who first treated this condition:				
Date first treated:				
8. If treatment was in a hospital emergency room, please provide name and address of hospital:				
9. Exact amount you are claiming under this plan:				

10. Are you or your dependent covered under any other insurance plan (including Medicare Supplement, Student Accident, Hospital Indemnity or Government plan)?	☐ Yes ☐ No

Please specify insurance carrier's name, address, policy number and daily benefit amount, if applicable, for any other insurance plan that you currently have, or any plan that has terminated since the effective date of your coverage below.

Name of Company	Address	Coverage Type	Policy#	Benefit Amount	Termination Date (if applicable)

Medical Authorization - Please sign the "Authorization For Release of Medical Information", as we may request a copy of the your medical records.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

In order to process a claim for benefits, I authorize any physician, hospital or other medical provider to release to Health Special Risk, Inc., or its representative any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed. I understand I have the right to receive a copy of this authorization.

Date	Name of Patient/Claimant	Signature of Patient/Claimant
/ /		

NOTE TO ALL PARTIES COMPLETING THIS FORM: Any person who, with intent to defraud or knowing that he/she 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.

Please return this claim form and EOB to the Plan Administrator:

Health Special Risk, Inc.
4100 Medical Parkway
CARROLLTON TX 75007
972-512-5680 fax
claims@hsri.com