



HSR Plaza II
 4100 Medical Parkway
 Carrollton, Texas 75007
 Phone (972) 492-6474 Fax (972) 492-4946
 Toll Free ((866) 243-7885

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 <input type="checkbox"/>	Certificate #:	Social Security #:
		Female <input type="checkbox"/>		
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?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Will you file for Workers' Compensation?				<input type="checkbox"/> Yes <input type="checkbox"/> 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:				

Please see the reverse side

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 JLT Services Corp., 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.
HSR Plaza II
4100 Medical Parkway
Carrollton, TX 75007*