MEDICAL QUESTIONNAIRE FORM

Administered by Seven Corners, Inc.
P.O. Box 21185, Eagan, MN 55121
Within the US: 1-800-461-0430
Outside the US: 317-818-2867
Fax: 317-575-6467

Instructions:
Additional information is required to complete the processing of you claims. Please complete this form, including signature and date, and mail the form to "Seven Corners" at the address indicated above or fax to "Attention Claims" at 317-575-6467. Receipt of this completed form will expedite the processing of claims. Thank you for your assistance.

The furnishing of this form must not be construed as an admission of any liability on Seven Corners, nor a waiver of any of the conditions of the ASPE health benefit plan.

1.) Current Effective Date _____/_____/_____ Current Termination Date: _____/_____/_____ Original Effective Date ASPE _____/_____/_____

2.) ID Number: _____ 3.) E-Mail Address: _____
(Required for claims processing)

4.) Name of Exchange Participant: _____ Date of Birth _____/_____/_____ Sex: ☐ Male ☐ Female

5.) Name of Patient: _____ Date of Birth _____/_____/_____ Sex: ☐ Male ☐ Female

6.) Current Residence Address: _____
_____

7.) Date of Arrival in Host Country: _____/_____/_____ Daytime Phone Number: (_____)_____

8.) Permanent Address (in Home Country): _____
_____

Where do you want your payments/correspondence to go: U.S. ☐ Outside of U.S. ☐ Please complete Payment Instructions Form.

9.) Date scheduled to return to Home Country: _____/_____/_____ ☐ Check here if return date is not yet determined.

10.) If Accident, provide details (i.e. how, when and where accident occurred): _____
_____

11.) If Illness, advise when and where symptoms first occurred and nature of illness: _____
_____

12.) Name and address of Consulting Physician: _____
_____

13.) Have you ever been treated for this illness before? Yes ☐ No ☐ If Yes, when? _____

14.) Provide Name and address of your Regular Physician in your Home Country: _____
_____

15.) Please advise names of any prescription medications you are presently taking: _____
_____

16.) Indicate other Health Insurance coverage, include name, address policy number and certificate number of Insurer: _____
_____

17.) If submitting bills for settlement please indicate total amount claimed, including currency of claim: _____

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 Claims Administrator named above or its representatives; any and all information with respect to any injury or illness suffered by; the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, illness or loss is the basis of claim and copies of all of that person's hospital or medical records, including in-formation relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the ID Number identified above. I authorize the employer or benefit plan administrators to provide the Claims Administrator named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the ID Number 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. In addition, I hereby certify that the above information is true and correct to the best of my knowledge and belief.

_____ _____
Signature of Patient or Parent if Patient is a Minor Date

Fraud Warning
In many jurisdictions of the United States, any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in prison.