ACCIDENT AND ILLNESS CLAIM FORM

Specialty Risk International, Inc.
303 Congressional Blvd.
Carmel, IN 46032
800-335-0477 or 317-575-2656 Fax: 317-575-2256

Insurance Carrier: Virginia Surety Company, Inc.
Name of Group: Short Term Missionary Medical Plan
Group Number: VSC05-050427-01TM
ID #: _____

Instructions:

1. This form is to be used when filing a claim for reimbursement of Medical Expenses and **must** be completed by the Insured in full.
2. Fully itemized bills including Claimant's Name, Nature of Illness/Injury, must be included with this claim form.
3. Description and Charge for each service provided.
4. This form must be signed and dated in all applicable sections. In most cases, two signatures are required.
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. Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

Coverage Effective Date _____/_____/_____ Coverage Termination Date _____/_____/_____

ID Number: _____ E-Mail Address: _____

1.) Name of Insured: _____ Date of Birth ___/___/___ Sex: ___Male ___ Female

2.) Name of Claimant: _____ Date of Birth ___/___/___ Sex: ___Male ___ Female

3.) Current Residence Address: _____

Date of Arrival in U.S.: _____/_____/_____ Daytime Phone Number: (_____)_____

4.) Permanent Address (In Home Country): _____

Date scheduled to return to Home Country: _____/_____/_____

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

_____

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

_____

7.) Name and address of Consulting Physicians: _____

_____

8.) Have you ever been treated for this Illness before? Yes___ No___ If Yes, when? _____

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

_____

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

_____

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

_____

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 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 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 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 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.

In addition, I hereby certify that the above information is true and correct to the best of my knowledge and belief.

_____ _____

Signature of Claimant or Parent, If Claimant is a Minor Date