

# BCS INSURANCE COMPANY

GROUP NAME or SPONSOR International Student Exchange Program (ISEP)		Insured's ID # (if applicable)
Name of Insured (SURNAME, First, MI)		Social Security # (if applicable)
Mailing Address	Date of Birth	Telephone #
		E-mail Address
Patient's Name	Date of Birth	Relationship to Insured
Date of Accident or Commencement of Sickness	Social Security # (if applicable)	
Description of Accident (How, When and Where) or Description of Sickness _____ _____ _____		
Have you had any prior treatment for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		

## INSURED INSTRUCTIONS FOR REPORTING A CLAIM

Please answer all questions.

Attach **original** itemized Invoices (bills) and submit to the address below.

Mail this form to:  
**INTERNATIONAL EDUCATIONAL EXCHANGE SERVICES**  
**P. O. Box 370**  
**Ithaca, NY 14851-0370**  
**Telephone 866-433-7462 (toll-free)**  
**607-272-2707**

**If answer is "Yes", what was the date?**

Are you employed?  Yes  No If "Yes" Employer's Name & Address \_\_\_\_\_

Is your Spouse employed?  Yes  No

Are your expenses covered by any other insurance?  Yes  No

**If you do have other insurance, what is the name, address and policy no. of that insurance policy?** \_\_\_\_\_

**Type of Insurance** \_\_\_\_\_ **Telephone #** \_\_\_\_\_

Have you or will you submit a claim against any other party for damages as a result of the illness or injury described in this form?  Yes  No

**If "Yes" please provide the Name, Address of the Insurance Company or Organization which sponsors the coverage.**

**IF PAYMENT IS TO BE MADE TO THE PROVIDER, SIGN BELOW**

I hereby authorize payment of benefits to any providers of service, otherwise payable to me for services, but not to exceed the reasonable and customary charge for those services. I understand that I am responsible for any charge not covered by this authorization.

Signed:	Date
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### AUTHORIZATION TO OBTAIN INFORMATION

To All physicians, hospitals, medical service providers, employers, consumer reporting agencies, law enforcement agencies and any other agencies or organizations (including other insurance companies, Blue Cross-Blue Shield, self insured and prepaid health plans) and specifically \_\_\_\_\_ Hospital(s), and Dr. \_\_\_\_\_

You are authorized to permit BCS Insurance Co. and its authorized representatives to view and obtain a copy of ALL RECORDS\* including employment, law enforcement, financial, insurance claim records and medical records as to examination, history, diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric, drug or alcohol treatment and any disease thereof.

\_\_\_\_\_  
Print name of Insured

I understand the information obtained will be used by BCS Insurance Co. to determine eligibility for insurance and benefits claimed under the insured's policy. I consent to redisclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold transferred or relayed to any other person not specified in this form without my written consent.

I understand this authorization may be revoked by written notice to BCS Insurance Co., but this will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not exceed a maximum of two years from the date below.

I know I may request a copy of this authorization. I also agree a photographic copy of this authorization shall be as valid as the original.

\*Limitations, if any:

Signed:	Date
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Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.