Health, Wellness and Vision Claim Form

This claim form is to be used only if your provider did not file Claims directly to International Claims Services (ICS) on your behalf. Return this form along with **itemized bills, diagnosis, and receipts**. ICS must receive claims within 180 days after first day of treatment.

Please send completed claim form and supporting documents to International Claims Services:

- **Online claims submission:** www.gbg.com
- **Submit:** eclaims@gbg.com / **Inquiries:** customerservice@gbg.com
- **Mail:** 27422 Portola Parkway, Suite 110, Foothill Ranch, CA 92610 USA
- **Fax**: +1.949.271.2330

A. PRIMARY INSURED INFORMATION	
Name (Last, First, MI):	
Policy #:	ID #:
Employer (if applicable):	
Date of Birth (DD/MMM/YYYY):	
Address:	
Postal Code:	Country:
Phone:	Fax:
Email:	
B. PATIENT INFORMATION (If different from Primary Insured)	
Name (Last, First, MI):	Patient: ☐ Dependent Spouse ☐ Dependent Child
Date of Birth (DD/MMM/YYYY):	
Address:	
Postal Code:	Country:
C. CLAIM INFORMATION	
Date illness/injury occurred (DD/MMM/YYYY):	
Is this claim for Maternity treatment? ☐ Yes ☐ No If yes, Delivery Date: _____.	
Describe problem, symptom or complaint:	
Physician's Diagnosis/Results of your visit:	
Has diagnosis/treatment for same condition or related condition been given previously? If so, provide dates, results, kind of treatment, prescribed drugs, name of doctor/facility:	

Treatment resulting from: a. The patient's occupation? ☐ Yes ☐ No If yes to any of the above, please provide date and details of accident:	b. An automobile accident? ☐ Yes ☐ No c. Any type of accident? ☐ Yes ☐ No
Is this patient also covered by: a. Other Group Health/Dental plan(s)? ☐ Yes ☐ No If yes to any of the above, please provide: Name of Carrier: Carrier Address:	b. Medicare / other Government Agency? ☐ Yes ☐ No c. No-fault auto carrier? ☐ Yes ☐ No Policy Number of other source:

PHYSICIAN/FACILITY INFORMATION

Physician/Facility/Provider Name:	
Address:	
Postal Code:	Country:
Phone:	Email:

RECEIPTS (In order to receive payment, please attach receipts and list treatments and/or prescribed drugs and the charges for each below)

Date of Service (DD/MMM/YYYY)	Description of each Service/Prescription Drug	Cost	Currency
	Total amount paid by Patient:		
	Total unpaid balance still due to Provider:		

D. REIMBURSEMENT METHOD	
Please reimburse: ☐ Primary Insured ☐ Provider (Payment by check)	
REIMBURSEMENT METHOD: Request preferred method of reimbursement below.	
☐ Check to Primary Insured's Address, as listed in PRIMARY INSURED INFORMATION section.	
☐ Check to other Mailing Address:	
☐ Send by Electronic Direct Deposit (U.S. banks only) or Wire Transfer (non-U.S. banks)	
Bank Name:	
Name on Account:	
Account #/IBAN:	
Routing #/ABA # (for Electronic Direct Deposit):	
SWIFT code (for Wire Transfer):	
Bank Address (for Wire Transfer):	

E. AUTHORIZATION	
Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. The above answers are true and correct to the best of my knowledge. I authorize any physician, medical institution, pharmacy, insurance company, employer, labor union, or association to release information to Global Benefits Group as required to properly pay all benefits, if any due to me, my spouse, or any other dependents. A photocopy of this authorization shall be considered effective and valid as the original.	
Insured Person	
Name:	Date:
Signature: By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual, handwritten signature.	