GLOBAL BENEFITS GROUP
Insurance Without Borders

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** to the address below. ICS must receive Claims within 180 days after first day of treatment.

COMPLETION OF ALL FIELDS BELOW IS REQUIRED TO PROCESS THIS REIMBURSEMENT REQUEST.

SECTION A. PRIMARY INSURED INFORMATION

Name (Last, First, MI):	Employer:	
Policy Number:	Member ID Number:	Email:
Current Resident Address and Country:		Phone Number:

SECTION B. PATIENT INFORMATION (Please check who this claim is for)

☐ Primary Insured ☐ Male ☐ Female	☐ Dependent Insured: ☐ Spouse ☐ Child
Date of Birth: _____	☐ Male ☐ Female Date of Birth: _____
☐ Married ☐ Single	Name: _____
Current Country of Residence: _____	Current Country of Residence: _____

SECTION C. CLAIM INFORMATION

Date illness / injury occurred:	Is the claim for Maternity treatment? ☐ Yes ☐ No Delivery Date: _____

Describe problem, diagnosis, symptom, or complaint:

Doctor's Diagnosis and/or results of your visit:

Has diagnosis and/or treatment for same condition or related condition been given previously? If so, state dates, results, kind of treatment, prescribed drugs, and name of doctor or facility:

Was illness or injury due in any way to:	**Is the patient also covered by:**
a. The patient's occupation? ☐ Yes ☐ No b. An automobile accident? ☐ Yes ☐ No c. Any type of accident? ☐ Yes ☐ No If yes, provide details, including date of accident:	a. Any other group health plan? ☐ Yes ☐ No b. Medicare or other Govt. Agency? ☐ Yes ☐ No c. No-Fault auto carrier? ☐ Yes ☐ No If yes, provide name and address of other source:
_____ _____ _____ _____	_____ _____ _____ _____

DOCTOR / FACILITY INFORMATION

Doctor / Facility / Provider Name:	Phone Number:
Address / Country:	
Provider email address (if available):	

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SECTION C. CLAIM INFORMATION (continued)

The following treatments and/or prescribed drugs were provided and the charges for each are listed below.

ATTACH RECEIPTS IN ORDER TO RECEIVE PAYMENT

Date of Service Day / Month / Year	Description of each service and/or prescribed drug	Cost	Currency
	Total Amount Paid by Patient:		
	Total unpaid balance still due to Provider:		

SECTION D. PAYMENT INFORMATION

Please make payment to: ☐ Member ☐ Provider (Payment by check)

PAYMENT TYPE (Please make payment as marked below):

☐ Member Address in Section A

☐ Other Mailing Address:

☐ Send by Electronic Direct Deposit (Bank must be located in US), or Wire Transfer (Banks located outside of US)

Name of Bank: _____

Name on Account: _____

Account # / IBAN: _____

Routing Number (ABA #) for electronic transfer: _____

SWIFT code for Wire Transfers: _____

Address of Bank for Wire Transfers: _____

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.

_____ Signature

_____ Date

Submit Claims to International Claims Services

- **Online Claims Submission available at www.gbg.com**
- Mail to: 26000 Towne Centre Drive, Suite 130
  Foothill Ranch, CA 92610 USA
- Fax to: +1 949-271-2330

Contact our Customer Service Department for Claims Inquires:

- Email: claims@gbg.com
- Call: USA Toll Free 1-877-916-7920
  Outside of USA +1 949-916-7941

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