# Consent Form for Submitting Claims

| **A. CONSENT FOR USE OF PERSONAL INFORMATION** (Does not apply to residents of the UK) | |
|---|---|
| **CLAIMANT'S NAME:** | **Requested Effective Date:**<br>(DD/MMM/YYYY, i.e., 01/NOV/2015) |

GBG Administrative Services, Inc., a company affiliated within GBG Group, is responsible for the processing of claims under your policy. Inter Partner Assistance has delegated claims processing authority to GBG Administrative Services, Inc. in accordance with the terms of their privacy policy.
Claim processing for this plan of benefits may require that you provide us with sensitive personal information about you and your enrolled dependents. In accordance with the privacy policy posted located in your policy documents, we will require your consent and the consent of those dependents you are submitting claims for to process this form.

The privacy policy provides information concerning the use and disclosure of your personal information including your rights under this policy. This privacy policy is in compliance with AXA's data protection policies and those of the European Union (EU) General Data Protection Regulation (GDPR). Throughout the year the terms of the privacy policy may be updated. You can find the most recent version in your policy

Your personal information, including special category or sensitive personal information such as medical and health details which you supply to the insurer may be used in many ways including, but not limited to: processing and underwriting your application for insurance, deciding whether an offer of insurance coverage can be made and on what terms, administering your policy and handling claims, and detecting and preventing fraudulent activity. Other companies affiliated with AXA Group and third parties who provide services to the insurer could use your information in the same manner and further detail in respect of the transfer of your data to third parties is contained in the privacy policy.

By ticking the box **"I CONSENT**", you consent to the use and disclosure of your healthcare information in accordance with the privacy policy. If you do not consent to the use and disclosure of your healthcare information, GBG will not be able to process your claim and therefore will not be able to provide you with insurance cover. The following claim form should only be completed if you are willing to provide consent.

| | |
|---|---|
| Primary Applicant Signature: | Printed Name: |
| ☐ **I CONSENT** | Date: |
| Spouse Signature:<br>(If dependent spouse applying for coverage) | Printed Name: |
| ☐ **I CONSENT** | Date: |
| Child Signature:<br>(Dependent children age 16 or older if applying for coverage) | Printed Name: |
| ☐ **I CONSENT** | Date: |

# Medical, Wellness and Vision Claim Information

*How to file your medical, wellness and vision claim*

Global Benefits Group (GBG) must receive claims within 90 days of treatment to be eligible for reimbursement of covered expenses. Claim forms should be submitted only when the medical service provider does not bill GBG directly, and when you have out-of-pocket expenses to submit for reimbursement.

**Claims Filing**

The best way to file your claim is to submit it online at **www.gbg.com.** Log into the Member Portal, select "Medical Claim Form", and follow the instructions to complete the online claim form. After submitting the claim, you will receive a claim reference number and an electronic receipt for the claim will be emailed to you.

If you are unable to submit your claim electronically, you can email, fax or mail your completed claim form ("Medical, Wellness and Vision Claim Form", Pages 2 through 4) and copies of supporting documentation.

**Submit claims by:**

- **Email**: eclaims@gbg.com
- **Fax**: +1.949.271.2330
- **Mail**: GBG Administrative Services, Inc.
  27422 Portola Parkway, Suite 110
  Foothill Ranch, CA 92610 USA

**Claim Reimbursement Options:**

- **Electronic Direct Deposit** for members where the receiving bank is located in the US.
- **Wire Transfer** for members and overseas providers where the receiving bank is located outside of the US.
- **Check** sent to member or provider where electronic payment is not possible.

**Status of Claims**

Members can check the claims status online by logging on to our website at www.gbg.com. Questions about a particular claim or claim reimbursement can be emailed to our Customer Service department at **customerservice@gbg.com.** Inquiries regarding the status of past claims must be received within 12 months of the date of service to be considered for review.

# Medical, Wellness and Vision Claim Form

This claim form is to be used only if your provider did not file Claims directly to Global Benefits Group (GBG) on your behalf. Return this form along with **itemized bills, diagnosis, and receipts.** GBG must receive claims within 90 days after first day of treatment.

**Please send completed claim form and supporting documents to GBG Administrative Services, Inc.:**

- **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 #: | GBG ID #: |
| Date of Birth:<br>(DD/MMM/YYYY, i.e., 23/NOV/1988) | Employer (if applicable): |
| Address: | |
| Postal Code: | Country: |
| Phone: | Fax: |
| Email: | |

| **B. PATIENT INFORMATION** | |
|---|---|
| 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

b. An automobile accident? ☐ Yes ☐ No

c. Any type of accident? ☐ Yes ☐ No

If yes to any of the above, please provide date and details of accident:

Is this patient also covered by:

a. Other Group Medical/Dental plan(s)? ☐ Yes ☐ No

b. Medicare / other Government Agency? ☐ Yes ☐ No

c. No-fault auto carrier? ☐ Yes ☐ No

If yes to any of the above, please provide:

Name of Carrier: Policy number of other source:

Carrier Address:

**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 |
|---|---|---|---|
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| | **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.<br><br>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:<br>By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual, handwritten signature. | |

**Fair Processing Notice**

The GBG Group includes insurance companies, brokering and management companies, as well as assistance and operations companies. We respect your privacy and we are all committed to protecting your personal information.

Our privacy policy tells you about your privacy rights and how the law protects you. This includes information on how we collect and then process your personal information. Our privacy policy is located on our website at https://www.gbg.com/#/AboutGBG/PrivacyPolicy and we would advise you to read the policy so you understand your rights and your personal data use by AXA Group and the GBG Group.