Medical Claim Form

EduCare International Plan[sm]

AAUG Insurance Company LTD
Claim Form, original itemized bills and all related correspondence must be mailed to:

Worldwide Expatriate Administrators
2525 Embassy Drive, Suite #15
Cooper City, Florida 33026 USA

Phone 1 (954) 889-2100
Fax 1 (954) 241-2002
Email info@wwexpa.com

TO BE COMPLETED BY INSURED - Please be sure to provide all requested information and include original itemized bills (invoices) from the healthcare provider.

A. INSURED (SUBSCRIBER) INFORMATION

1. Insured's Name (Last, First, MI) ____ 2. Alias Name(s) ____
3. Mailing Address ____
Country: ____ Zip / Postal Code: ____
4. E-mail Address ____
5. Home Phone Number ____ 6. Policy Number ____
7. Work Phone Number ____ 8. Fax Number ____

B. PATIENT INFORMATION

9. Patient's Name (Last, First, MI) ____ 10. Alias Name(s) ____
11. Patient's Date of Birth (MM/DD/YY) ____ 12. Patient's Relationship to Insured ____
13. Describe Illness or Injury *(If maternity, please complete and include maternity form)* ____
14. Date of Illness (first symptoms) or injury (MM/DD/YY) ____
15. Do you or any member of your immediate family have any other insurance that may cover all or part of this claim? Yes ☐ No ☐
16. IF YES (to #15), give insurance company name, address & policy # and Effective Date.
____

C. ASSIGNMENT OF BENEFITS

17. Assignment: Please pay provider directly to the address indicated on the attached original provider invoice. Yes ☐ No ☐
18. Insured's Signature ____ 19. Date Signed ____

D. AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, or employer having certain information about me or my dependents to give to AAUG Insurance Ltd and or Worldwide Expatriate Administrators or its legal representative, any and all such information. The nature of the information authorized to be disclosed includes information about: (1) physical condition(s); (2) health history(ies); (3) age(s); and (4) personal characteristics. This authorization includes information about: (1) drugs; (2) alcoholism or; (3) mental illness; or (4) communicable diseases.

I UNDERSTAND the information obtained by use of the Authorization will be used by AAUG Insurance Co. Ltd. and or Worldwide Expatriate Administrators to determine eligibility for benefits. I ALSO AUTHORIZE AAUG Insurance Co. Ltd and or Worldwide Expatriate Administrators to release any information obtained to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as I may further authorize.

20. Insured's Signature ____ 21. Date Signed ____

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E. FRAUD WARNING

Any person, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, who submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

SECTIONS F, G TO BE COMPLETED BY MEDICAL PROVIDER OF SERVICES

Please be sure to provide all requested information.

EACH BILL MUST INDICATE:

1) DIAGNOSIS
2) NAME OF MEDICATIONS, PRESCRIPTIONS AND INJECTIONS
3) NAME AND ADDRESS OF PROVIDER
4) TYPE OF CURRENCY
5) DATE OF SERVICE
6) DESCRIPTION OF SERVICES
7) IF SERVICES ARE ROUTINE (WELLNESS)
8) MATERNITY CLAIMS MUST INCLUDE A FULLY COMPLETED MATERNITY QUESTIONNAIRE (AVAILABLE ON LINE)

SELECT TYPE OF SERVICE: ☐ Routine Wellness ☐ Medical ☐ Maternity ☐ Routine Vision

F. PHYSICIAN OR PROVIDER INFORMATION

Date of Service	Location of Service	Procedure (Service Description)	Diagnosis	Charges Type of Currency

G. AUTHORIZATION

Please note that a physicians signature is **not** required if fully itemized invoices are being attached.

22. Physician or Provider of Services Signature ______

23. Date Signed ______

24. Name and Address of Provider (Print) ______

WEA MEMBER

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