Life Benefit Claim Form

Please print legibly and complete ALL SECTIONS of this form. Mail, fax, or email completed form to:
Address: International Medical Group, Inc. Claims, P.O. Box 240429, Apple Valley, MN 55124 USA,
Call: +1.800.628.4664 or outside U.S. +1.317.655.4500; **Fax:** +1.317.655.4505
Email: customercare@imglobal.com

This form is to be completed by the person or persons to whom the policy benefits are legally payable as beneficiary under the terms of the Certificate. If the beneficiary is the insured's estate, the statement should be completed by the executor or administrator and a certified copy of the appointment issued by the proper court should be attached. If the beneficiary is not of legal age, a guardian or custodial parent must also sign this document.

Group #:	Certificate or Social Security #:
Name of Deceased:	Relationship to Insured:
Residence at Time of Death:	Cause of Death:
Date of Death: ___/___/___ *(MM/DD/YYYY)*	Place of Death:
Date of Birth: ___/___/___ *(MM/DD/YYYY)*	Place of Birth:
Employer:	

FRAUD STATEMENT

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. (I.C. § 35-43-5-3.5)

AUTHORIZATION TO OBTAIN INFORMATION

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 CFR §164.5080].
This is your authority to allow the bearer hereof, who is acting on behalf of International Medical Group, to examine or copy any and all records, reports, correspondence, medical bills, medical reports, claim information, payout information, referral requests, and approvals regarding the person named below, under the insurance certificate number _____, insured ID # _____, DOB _____ and policy holder _____ .

The cost of any copies or reports shall be at the expense of International Medical Group. A reproduction of this authorization shall be considered as good and valid as the original.

Dated this _____ day of _____ , 20_____ . X _____
Signature

State of _____ SS: _____

Country of _____

Before me, a Notary Public, in and for said County and State, personally appeared, _____ ,

who acknowledged the execution of the foregoing, and who first being duly sworn, stated that the facts contained herein are true.

Witness my hand and seal this _____ day of _____ , 20 _____ . X _____
Signature

_____
Printed Name

My Commission Expires: _____ My Country of Residence is: _____

Personally known _____ OR Produced identification _____ Type of identification produced _____

GENERAL INSTRUCTIONS FOR SUBMITTING PROOF OF DEATH:

1. Certified copy of official death certificate
2. Newspaper clipping or article pertaining to death or burial should be furnished, if possible
3. Reverse side should be completed by beneficiary or beneficiaries
4. If claim is being made for Accidental Death Benefits, a copy of the police report or coroner's report should be furnished

A guardian or parent signing this on behalf of a minor beneficiary should attach sufficient identification or court-appointment documents to establish the relationship he or she has to the minor beneficiary.

If any primary beneficiary or co-beneficiary is deceased, a certified copy of the Death Certificate of the deceased beneficiary is required.

If there is more than one beneficiary, all may sign the same Life Benefit Claim Form or if desired, a separate form for each beneficiary may also be completed.

INFORMATION ABOUT THE BENEFICIARY *(Please print).*

Beneficiary's Name:	Date of Birth: ___/___/___ *(MM/ DD/YYYY)*
Beneficiary's Address:	Phone:
Relationship to the Deceased (if any):	

ALTERNATE PAYEE INFORMATION

Name:			
Street Address:		Phone:	
City:	State:	Postal Code:	Country:
Email:			

PAYMENT DETAILS (Checks will only be issued to a United States address.)

☐ Make payment to the provider			
☐ Make payment to primary insured	Reimbursement method	☐ Bank ACH or wire transfer (complete below)	☐ Check
☐ Make payment to alternate payee	Reimbursement method	☐ Bank ACH or wire transfer (complete below)	☐ Check

Account Holder's Name:		
Bank Name:		
Bank Address:	City:	Country:
Currency of reimbursement:	Bank 9 digit ABA number—U.S. banks:	
Bank 8 or 11 digit SWIFT code—non-U.S. banks:	Sort code:	
Bank account number:	Bank IBAN:	
Intermediary Bank Details *(if applicable):*		
Name of intermediary bank:		
Intermediary bank SWIFT code:	Intermediary bank account number:	

If needed you can overnight packages to following address:
International Medical Group, Inc. Claims, P.O. Box 240429, Apple Valley, MN 55124 USA