GLOBALSELECT℠ GROUP CLAIM FORM

INTERNATIONAL MEDICAL GROUP®

Must be submitted to International Medical Group® within 180 days of date of service

PART A. CLAIMANT/PATIENT INFORMATION - TO BE COMPLETED AND SIGNED BY THE CLAIMANT FOR ALL CLAIMS

Claimant/Patient Name (Last, First, Middle):		
❑ Male ❑ Female	Date of Birth (dd/mm/yy):	Claimant's Relationship to Primary Insured: ❑ Self ❑ Spouse/Partner ❑ Child ❑ Other
Name of Primary Insured (as appears on ID card):		
❑ Male ❑ Female		Date of Birth (dd/mm/yy):
Claims Correspondence Address:		
Home Tel: +	Mobile Tel: +	Email:
Group ID # (as appears on ID card):		ID # (as appears on ID card):

If claimant is covered by another plan, complete items below

Name of Primary Insured (as appears on ID card):	Date of Birth (dd/mm/yy):
Group name of other plan:	Policy # of other plan:
Name of other carrier/insurer:	
Insurers Address:	
City: State/Region:	Zip/Postal Code:
Country:	

PART B. CLAIMS INFORMATION

What are the symptoms of your illness or name the conditions if you have received a medical diagnosis from a physician:

Date when symptoms first occurred (dd/mm/yy):

Are symptoms or medical condition due to an accident or injury? ❑ Self ❑ Spouse/Partner
If yes, please provide details of where and how it occurred:

Have you ever been treated for this illness/condition before? ❑ Self ❑ Spouse/Partner
If yes, please provide the details, name and address of the treating physician along with the date(s) of the treatment:

Date of service (dd/mm/yy)	Provider	What type of service was provided?	What was the condition/ injury?	City/Country	Type of currency paid or billed	Total charge paid or billed	Converted to U.S. Funds *(if requesting payment in USD)*	Office use only

PART C. CLAIMS REIMBURSEMENT- Alternate Payee Request- Must be completed by Parent or Guardian if insured is under 18 years of age. An alternate payee may be elected to receive payment by draft when requested payment is to someone other than insured or provider of medical service(s).
Print name of requested alternate payee:
Print mailing address for alternate payee draft, if requesting a different location than the insured:

WIRE TRANSFER REQUEST (for payments to insured)- If payment is to be sent by wire transfer, please indicate below by completing full details of bank and/or transfer information (Wire cannot be honored if below is incomplete or inaccurate. If no currency is requested, claims will be settled in USD.)
Name of account holder (how it appears on account):
Bank account (U.S.) or IBAN (non-U.S.):
Sort or Swift Code (non-U.S. bank):
Routing number (U.S. bank):
Requested currency for transfer:
Bank name:
Bank phone number:
Bank address:

PART D. AUTHORIZATION - TO BE COMPLETED BY THE CLAIMANT FOR ALL CLAIMS

I verify that all information contained in this form is true, correct, and complete to the best of my knowledge.

I authorize any licensed doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial or employment status of the insured named below, to provide this information to International Medical Group®, Inc. or any agent or administrator acting on its behalf.

I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be as valid as the original. This authorization is valid for twelve (12) months from the date signed.

Print Name:_____

Signature of Insured/ Guardian:_____ Date (dd/mm/yy):_____

AUTHORIZATION: I authorize payment of medical benefits to the doctor or other supplier of services submitting the attached bills.

Signature of the Insured/ Guardian:_____ Date (dd/mm/yy):_____

Please forward your completed Claim Forms and all relevant original copies of receipts and invoices to:

IMG Europe Ltd.
36-38 Church Road, Burgess Hill
West Sussex, RH15 9AE
United Kingdom
Phone: +44 (0) 1444 46 55 55
Fax: +44 (0) 1444 46 55 50
Email: claims@imgeurope.co.uk