CLAIM FORM

POLICY: # 4.083.739 - Nacel Open Door ❍ Personal Accident ❍ Illness

First Name	Last Name	Birthdate (MONTH/DAY/YEAR)
Group Code	Home Country	Area Code & Phone No. of Host Family
Host Family Name and Address		

PERSONAL ACCIDENT	**ILLNESS**
What kind of injury is the consequence of accident?	Diagnosis and symptoms of illness
When did the accident occur?	
How and where did the accident happen?	When did you first notice the symptoms of illness?
Have you previously suffered from the same illness or injury? ❍ YES ❍ NO	
Date of service rendered	
Name of doctor you consulted	
Have you been treated at a hospital? ❍ YES ❍ NO If yes, hospital name and address	Date(s): From To

SPECIFICATION OF COSTS *(attach original bills/receipts with diagnosis)*

TYPE OF COST INCURRED (medicine, doctor, hospital travel, etc.)	AMOUNT OF CLAIM	WHO HAS PAID THE BILL? REFUND TO:

SIGNATURE This claim should be signed by the insured, or if he or she is incapable of doing so, signed by the host family or Nacel Open Door coordinator/representative.

I hereby authorize those doctors, who are giving me or have previously given me treatment, as well as any insurer, social insurance office or similar, where I am of have been covered under a personal accident or medical insurance, to supply the insurance company and Nacel Open Door with all information required on my state of health for considering my claim.

DATE SIGNATURE

CLAIM FORM MUST BE COMPLETED IN FULL

To make a claim, please return this form to:

Nacel Open Door, Inc. *· 380 Jackson Street, Ste. 200 · St. Paul, MN 55101*

Attn: Student Health Insurance