ISO Student Health Insurance

Insurance Claim Form

You must submit all claim documents to our claim's administrator, SISCO Benefits, within **90 days** from the date of service. The insurance company maintains its right to investigate, request additional information, and verify eligibility or other terms for claims processing.

Member Name (First Name Last Name):	
Insurance ID Number:	**Date of Birth (MM/DD/YYYY):**

Answer ALL questions below:

1) **Do you or your dependents have any other insurance or medical plan?** ☐ YES ☐ NO
   a. If yes, please provide a copy of your other insurance ID card.
2) **If this claim is for your dependent, please provide:**
   a. Dependent's Name: _____ b. Dependent's Date of Birth (MM/DD/YYYY): _____
3) **Were you treated at the Student Health Center?** ☐ YES ☐ NO
4) **Did you pay for this claim?** ☐ YES, please submit the receipt ☐ NO
5) **What is this claim for? (select one and only complete the corresponding section)**

   ☐ Preventative Care → Proceed to Section A

   ☐ Illness/Prescription → Proceed to Section B

   ☐ Accident/Injury → Proceed to Section C

Section A: Preventative Care

a. Date (MM/DD/YYY) you received service: _____
b. Describe the service you received: _____
   _____
c. Did you receive this service at the pharmacy? ☐ YES, please submit the pharmacy slip ☐ NO

Section B: Illness/Prescription Claim

a. Date (MM/DD/YYYY) when symptoms first occurred: _____
b. Describe symptoms: _____
   _____
c. Date (MM/DD/YYYY) you first consulted a physician: _____
d. Have you received any previous treatments for this illness? ☐ YES ☐ NO
   If yes, please describe past treatment and dates (MM/DD/YYYY): _____
   _____

Section C: Accident/Injury Claim

a. Date (MM/DD/YYYY) of the injury: _____ Time of injury/accident (Eastern Standard Time): _____

b. Describe **how** and **where** the injury occurred (home, work, etc.):

_____

_____

c. Specify the injured body part (include left or right): _____

d. Was the injury a result of an auto accident? ☐ YES ☐ NO

e. Were you injured while working on the job? ☐ YES ☐ NO

f. Is any Third Party responsible for this injury/accident? ☐ YES ☐ NO

g. Is your injury related to sports participation? ☐ YES ☐ NO

If yes, please specify the type of sports: ☐ Intercollegiate ☐ Intramural ☐ Club ☐ Recreational

h. Have you received treatment for this injury in the past? ☐ YES ☐ NO

If yes, please provide the treatment date (MM/DD/YYYY): _____

Reimbursement: If there is a reimbursement, how would you like to receive payment?

☐ Check - Provide your U.S. mailing address to receive the reimbursement check:

Address: _____ City: _____ State: _____ Zip code: _____

-OR-

☐ ACH (**Electronic Payment to U.S. Bank Account**)

a. Have you provided your U.S. bank information to SISCO before?

☐ YES ☐ NO, please complete the Direct Deposit Authorization form on the next page

Submission: Submit all documents by using one of the following methods:

- **Upload**: Click on 'My claims' section in your ISO account
- **Email**: ISOservice@siscobenefits.com
- **Mail**: SISCO Benefits, PO Box 3190, Dubuque, IA 52004-3190

>>>>> Attention: Your claim will not be processed without an itemized bill <<<<<

Please allow 15-30 business days for claim processing. You can check claim status online by clicking on 'My claims' section in your ISO account or by calling 833 -577-2586 Monday – Thursday 8:30 AM to 7:00 PM or Friday 8:30 AM to 5:00 PM EST.

I authorize any physician, hospital, company, employer or organization to release the medical history, treatments or benefits **payable** for this claim to SISCO Benefits or its payor for which it is an authorized plan administrator. A photocopy of this form shall be just as valid as the original. I authorize SISCO Benefits or its representatives to pay all bills in conjunction with this claim directly to the physician, hospital or other health care provider rendering service.

I certify that I have read all answers to this form, and to the best of my knowledge the information I have given is complete and true. Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty (not to exceed five thousand dollars in New York) and the stated value of the claim for each violation.

Signature of Claimant: _____ Date (MM/DD/YYYY): _____

SisCo
experience the benefits

Direct Deposit Authorization Form
For Insurance Claim Payments

Automatic Direct Deposit is a convenient feature for members to receive their claim payment(s). If you decide to take advantage of Automatic Direct Deposit, your approved claim(s) will be deposited automatically into the U.S. bank checking or savings account you provide. By completing the Authorization Form below and providing a copy of a voided check or savings deposit slip, you are authorizing SisCo Benefits and your financial institution to deposit your insurance payment(s) into your checking or savings account.

Direct Deposit Form	Request Type*: ☐ New ☐ Update
Group Name: - ISO International Student Insurance	Group Number: – ISO GROUP
Member Name:	Member Insurance ID:
Member Mobile Phone Number:	Member Email Address:
Financial Institution (Bank Name):	Financial Institution (Bank) Phone Number:
Checking/Savings Account Routing # -9 Digits:	Checking/Savings Account # 6-13 Digits:
Account is a checking or savings account ☐ Savings	☐ Checking

*This form only needs to be submitted with the **FIRST** payment. All subsequent payments for the indicated coverage will automatically be processed via ACH until SisCo Benefits is notified in writing of a requested change. Change requests should be sent to ISOACH@siscobenefits.com.

I hereby authorize SisCo Benefits to deposit insurance payment(s) directly into my checking or savings account indicated above. I also authorize the financial institution named above to accept my deposit(s) and to credit the amount to my account.

I understand that this authorization will remain in full force and effect for the coverage indicated above until I notify SisCo Benefits in writing that I wish to revoke this authorization. I understand that SisCo Benefits requires at least 7 days prior notice of my next payment in order to cancel this authorization.

Signature _____ Date _____

Please attach this completed form and a copy of a voided check or savings deposit slip to your completed insurance claim form.

Completed claim forms and direct deposit authorization forms can be emailed to ISO ACH at ISOACH@siscobenefits.com or ISO Claims at ISOservice@siscobenefits.com

CLAIM FORM FRAUD STATEMENT - FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ALASKA and KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA: WARNING :Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TENNESSEE and VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.