1. FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
3. MAIL TO HSR

EMAIL: Berkley@HSRI.com

HSR
ACCIDENT INSURANCE SOLUTIONS

Berkley
Accident and Health
a Berkley Company

EMERGENCY EVACUATION AND REPATRIATION CLAIM FORM

Insurance coverage is underwritten by Berkley Life and Health Insurance Company, (domiciled in Iowa - California Certificate of Authority #08527) or StarNet Insurance Company (domiciled in Iowa - California Certificate of Authority #6978)

MAIL CLAIM TO:
Health Special Risk II
8400 Belleview Dr, Suite 150, Plano, TX 75024

Health Special Risk herein referred to as the "Administrator"
Phone: (972) 512-5600 Fax: (972) 512-5820
Toll Free: (866) 523-3269 Email: Berkley@HSRI.com

PART 1 – POLICYHOLDER'S REPORT

POLICYHOLDER:	POLICY NUMBER:
CLAIMANT'S NAME (INJURED PERSON):	
The SOCIAL SECURITY NUMBER OF INJURED PERSON: *Please note that the Injured Person's Social Security Number MUST be provided as required by the Center for Medicare Services.*	
GENDER: ☐ M ☐ F DATE OF BIRTH:	EMAIL:
ADDRESS OF INJURED PERSON AND BEST CONTACT PHONE NUMBER (INCLUDE AREA CODE). Policyholder address will be used in lieu of claimant address when not available.	
IF APPLICABLE, PARENT'S NAME, ADDRESS, AND BEST CONTACT PHONE NUMBER (INCLUDE AREA CODE):	

DATE & TIME OF ONSET:	PLACE OF OCCURRENCE:	THE CLAIMANT IS: ☐ Employee ☐ Spouse ☐ Dependent Child
MEDICAL REASON FOR EVACUATION AND/OR REPATRIATION:		DID THIS INJURY RESULT IN DEATH? ☐ YES ☐ NO

DESCRIBE HOW THE INJURY OCCURRED. Please give all possible details.

DID INJURY OCCUR (CHECK YES OR NO FOR EACH OF THE FOLLOWING):

A. During a policyholder programmed, sponsored & supervised, or sanctioned activity?	☐ YES ☐ NO
B. On activity premises?	☐ YES ☐ NO
C. While on the job (if applicable)?	☐ YES ☐ NO
D. While traveling directly and uninterruptedly to or from home and policyholder premises?	☐ YES ☐ NO

NAME OF REPRESENTATIVE WHO SECURED AUTHORIZATION:

APPROVER NAME & PHONE NUMBER:

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize any licensed physician; medical practitioner; hospital; clinic or other medical facility; insurance company; employer; Medical Information Bureau; Motor Vehicle Administration or other organization; or persons that have any records or knowledge of me or my physical or mental health condition to give Berkley Group Companies (Berkley Life and Health Insurance Company or StarNet Insurance Company), its authorized Administrator or their legal representative, and any agent acting on their behalf any such information. I also authorize any Berkley Group Company or its authorized Administrators or their legal representatives, to release medical and billing information to any family member or health care provider if necessary to facilitate any potential payments.

I understand that this information will be used to determine my eligibility for coverage and that I may revoke this authorization at any time by providing written notice to Berkley Group Company or its authorized Administrator. I understand that I may revoke this authorization except to the extent that action has already been taken based upon this authorization. The revocation may not take effect before the date received by Berkley Group Company or its authorized Administrator.

A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for 24 months from the date below (In AZ, CA, CT, GA, HI, IL, ME, MA, MN, NV, NC, NJ, NM, OH, and VA authorization shall be valid during the duration of the claim. In WI, authorization is valid during the duration of the claim or 24 months, whichever is longer). I acknowledge that I, or my authorized representative, am entitled to receive a copy of this authorization upon request.

I understand that the authorized Administrator may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed pursuant to this Authorization, the information will remain protected by the authorized Administrator in accordance with federal or state law.

DECLARATION: These statements are true and complete to the best of my knowledge.

FRAUD WARNING: 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. **FOR RESIDENTS OF NEW YORK:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Fraud language varies by state. Please see below.)

SIGNATURE OF AUTHORIZED REPRESENTATIVE	TITLE OF AUTHORIZED REPRESENTATIVE	DATE

***Attention California Residents - please refer to following link for an important notice regarding the collection of Personal Information. https://www.berkley.com/privacy#californiaCollectionAtNotice**

By entering your name above, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.

STATE SPECIFIC FRAUD WARNINGS

FOR RESIDENTS OF ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

FOR RESIDENTS OF 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.

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

FOR RESIDENTS OF 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.

FOR RESIDENTS OF DELAWARE AND IDAHO: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

FOR RESIDENTS OF FLORIDA: 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.

FOR RESIDENTS OF INDIANA: A person who knowingly and with intent to defraud an insurer file a statement of claim containing any false, incomplete, or misleading information commits a felony.

FOR RESIDENTS OF KANSAS: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

FOR RESIDENTS OF 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 information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

FOR RESIDENTS OF 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.

FOR RESIDENTS OF MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

FOR RESIDENTS OF MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

FOR RESIDENTS OF 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.

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

FOR RESIDENTS OF NEW MEXICO: 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 CIVIL FINES AND CRIMINAL PENALTIES.

FOR RESIDENTS OF OHIO AND OKLAHOMA: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

FOR RESIDENTS OF OREGON: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

FOR RESIDENTS OF 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.

FOR RESIDENTS OF VERMONT: Any person who knowingly presents a false statement in a claim for proceeds of an insurance policy may be guilty of a criminal offense and subject to penalties under state law.