GLOBAL BENEFITS GROUP
Insurance Without Borders™

Health, Wellness and Vision Claim Information

How to file your health, wellness and vision claim

International Claims Services (ICS) must receive claims within 180 days of treatment to be eligible for reimbursement of covered expenses. Claim forms should be submitted only when the medical service provider does not bill ICS directly, and when you have out-of-pocket expenses to submit for reimbursement.

Claims Filing

The best way to file your claim is to submit it online at www.gbg.com. Log into the Service Portal, select "Health Claim Form", and follow the instructions to complete the online claim form. After submitting the claim, you will receive a claim reference number and an electronic receipt for the claim will be emailed to you.

If you are unable to submit your claim electronically, you can email, fax or mail your completed claim form ("Health, Wellness and Vision Claim Form", Pages 2 through 4) and copies of supporting documentation.

Submit claims by:

- Web: www.gbg.com
- Email: eclaims@gbg.com
- Fax: +1.949.271.2330
- Mail: International Claims Services
  27422 Portola Parkway, Suite 110
  Foothill Ranch, CA 92610 USA

Claim Reimbursement Options:

- Electronic Direct Deposit for members where the receiving bank is located in the US.
- Wire Transfer for members and overseas providers where the receiving bank is located outside of the US.
- Check sent to member or provider where electronic payment is not possible.

Status of Claims

Members can check the claims status online by logging on to our website at www.gbg.com. Questions about a particular claim or claim reimbursement can be emailed to our Customer Service department at customerservice@gbg.com. Inquiries regarding the status of past claims must be received within 12 months of the date of service to be considered for review.

Claim Appeal

If you do not agree with the outcome of a processed claim, you may submit an appeal online at www.gbg.com. Alternatively, you can send a completed Appeals Form (available at www.gbg.com) and supporting documents to:

- Email: customerservice@gbg.com
- Fax: +1.949.271.2330
- Mail: International Claims Services
  ATTN: Appeals Department
  27422 Portola Parkway, Suite 110
  Foothill Ranch, CA 92610 USA

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Health, Wellness and Vision Claim Form

This claim form is to be used only if your provider did not file Claims directly to International Claims Services (ICS) on your behalf. Return this form along with **itemized bills, diagnosis, and receipts**. ICS must receive claims within 180 days after first day of treatment.

Please send completed claim form and supporting documents to International Claims Services:

- **Online claims submission:** www.gbg.com
- **Submit:** eclaims@gbg.com / **Inquiries:** customerservice@gbg.com
- **Mail:** 27422 Portola Parkway, Suite 110, Foothill Ranch, CA 92610 USA
- **Fax:** +1.949.271.2330

A. PRIMARY INSURED INFORMATION	
Name (Last, First, MI):	
Policy #:	GBG ID #:
Employer (if applicable):	
Date of Birth: (DD/MMM/YYYY, i.e., 23/NOV/1988)	
Address:	
Postal Code:	Country:
Phone:	Fax:
Email:	
B. PATIENT INFORMATION (If different from Primary Insured)	
Name (Last, First, MI):	Patient: ☐ Dependent Spouse ☐ Dependent Child
Date of Birth (DD/MMM/YYYY):	
Address:	
Postal Code:	Country:
C. CLAIM INFORMATION	
Date illness/injury occurred (DD/MMM/YYYY):	
Is this claim for Maternity treatment? ☐ Yes ☐ No If yes, Delivery Date:	
Describe problem, symptom or complaint:	
Physician's Diagnosis/Results of your visit:	
Has diagnosis/treatment for same condition or related condition been given previously? If so, provide dates, results, kind of treatment, prescribed drugs, name of doctor/facility:	

Treatment resulting from:	b. An automobile accident? ☐ Yes ☐ No
a. The patient's occupation? ☐ Yes ☐ No	c. Any type of accident? ☐ Yes ☐ No
If yes to any of the above, please provide date and details of accident:	
Is this patient also covered by:	b. Medicare / other Government Agency? ☐ Yes ☐ No
a. Other Group Health/Dental plan(s)? ☐ Yes ☐ No	c. No-fault auto carrier? ☐ Yes ☐ No
If yes to any of the above, please provide:	
Name of Carrier:	Policy Number of other source:
Carrier Address:	
PHYSICIAN/FACILITY INFORMATION	
Physician/Facility/Provider Name:	
Address:	
Postal Code:	Country:
Phone:	Email:

RECEIPTS (In order to receive payment, please attach receipts and list treatments and/or prescribed drugs and the charges for each below)

Date of Service (DD/MMM/YYYY)	Description of each Service/Prescription Drug	Cost	Currency
	Total amount paid by Patient:		
	Total unpaid balance still due to Provider:		

D. REIMBURSEMENT METHOD	
Please reimburse: ☐ Primary Insured ☐ Provider (Payment by check)	
REIMBURSEMENT METHOD: Request preferred method of reimbursement below.	
☐ Check to Primary Insured's Address, as listed in PRIMARY INSURED INFORMATION section.	
☐ Check to other Mailing Address:	
☐ Send by Electronic Direct Deposit (U.S. banks only) or Wire Transfer (non-U.S. banks)	
Bank Name:	
Name on Account:	
Account #/IBAN:	
Routing #/ABA # (for Electronic Direct Deposit):	
SWIFT code (for Wire Transfer):	
Bank Address (for Wire Transfer):	

E. AUTHORIZATION	
Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. The above answers are true and correct to the best of my knowledge. I authorize any physician, medical institution, pharmacy, insurance company, employer, labor union, or association to release information to Global Benefits Group as required to properly pay all benefits, if any due to me, my spouse, or any other dependents. A photocopy of this authorization shall be considered effective and valid as the original.	
Insured Person	
Name:	Date:
Signature: By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual, handwritten signature.	