Team Leader Procedure Guide

Thank you for purchasing the IMG OUTREACH Plan. This document includes tips for team leaders and travelers as well as resources for filing a successful claim. We highly recommend reviewing and printing the following before departure.
If you have any questions, please feel free to contact us at 1-800-576-2674 (9-4 MST) or www.missiontripinsurance.com.

Tips for Team Leaders:

1. **IF SOMEONE IS HURT**, injured, or in an accident, and you are unsure of what to do…call the IMG Emergency Assistance Line (collect) at 1-317-655-4500. **ALL hospitalizations or in-patient procedures and surgeries MUST pre-certify.**
To pre-certify please call IMG collect… 1-317-655-4500

2. **FOLLOW UP TREATMENT**…If someone is injured but wants to wait until they get back to the US for treatment…in order to use this insurance back in the US (for up to 6 months from the beginning of one claim) they must initiate a claim while this policy is in force…and while on the trip. Go see a doctor and create an invoice (even if the doctor only diagnoses, but does not treat) which will prove when the incident took place or call the IMG Emergency Assistance Line.

3. **DOCUMENT EVERYTHING!**
If you need to go to the doctor or clinic, get a receipt for the bill. The documentation of a doctor's receipt, medical bill, or travel delay is an absolute **MUST** in filing a successful claim.

4. **ALL EVACUATIONS MUST BE COORDINATED THROUGH IMG.**
If you believe you need an evacuation, call the emergency phone number listed on your confirmation and they will coordinate the evacuations. Evacuations coordinated through a third party will not be covered.

5. **WHEN IN DOUBT CALL.**
Insurance Consultants is available during normal work hours (9 am -4 pm MST) to answer questions about coverage and policy wording. If you have an emergency while overseas or during non-work hours, call the emergency assistance number listed on your confirmation.

INSURANCE AND TRAVEL ASSISTANCE PROCEDURES

Insurance Carrier: **INTERNATIONAL MEDICAL GROUP**

Name of Plan: **GROUP OUTREACH TRAVEL MEDICAL**

Emergency Assistance Phone Numbers:

Within the USA & Canada: 1-800-628-4664
Outside USA and Canada: +44 (0) 1444.46.5577 or 01-317-655-4500 (call collect)
Fax: +44 (0) 1444.46.5550
Email: insurance@imglobal.com
Online Provider Network: www.imglobal.com/provider
*When outside the USA or Canada, you will first have to call the local telephone operator for help in placing you're collect call, or if dialing direct, enter the International Access Code of the country you are calling from.

IMG OUTREACH Post Departure Benefits:

$50,000 - $100,000 - $250,000 - $1,000,000…....Medical Benefit
(depending on the level you chose)
$0 - $100 - $250 ……..Deductible
(depending on what you chose)
$500,000 ……Emergency Medical Transportation
$50,000…… Repatriation
$25,000 ……..Accidental Death and Dismemberment
$50,000 …… Common Carrier Accidental Death
See Additional information in the Benefit section.

This plan does not include trip cancellation or interruption benefits. This plan does not cover preexisting conditions unless… **(U.S. citizens only)** For those up to age 65 with a primary health plan, Outreach Group International will pay the Usual, Reasonable and Customary charges of a sudden and unexpected recurrence of a Pre-existing Condition (defined on the Exclusions page) up to the plan maximum. For those without a primary health plan, Outreach Group International will pay up to a $20,000 lifetime maximum. For those age 65 and older, with or without a primary health plan, Outreach Group International will pay up to a $2,500 lifetime maximum. The primary health plan must have existed prior to the effective date and during coverage of the Outreach Group plan, and the Pre-existing Condition must be covered under the primary health plan. **(Non-U.S. citizens only)** For those under age 65, Outreach Group America will pay up to a $50,000 lifetime maximum for eligible medical expenses. For those age 65 and older, Outreach Group America will pay up to $2,500 lifetime maximum. *Please see your policy certificate for details.*

Team Leader Resources:

Below you will find the following resources for team leaders:

- Trip Leader Medical form
- Assignment of Benefits form
- IMG Claim Filing Instructions & Interactive Claim Form

These tools will help you gather the information you will need to document a claim. To file a claim, go to IMGLOBAL.com to create an ONLINE claim or call the claims department at 1-800-628-4664.

Trip Leader Medical Form

This is not a claim form. The purpose of this form is to gather information that will help you process a successful claim when you get back to the states. **Remember that documentation is crucial to a successful claim.** You may want to take several copies with you.

*If someone will be submitting a medical claim, they will want to attach copies itemized bills/or statements from medical providers for services rendered in connection with the claim. The information must include date of service, the service rendered, the charge for each service and the diagnosis. This insurance plan is in excess of other group, government or blanket health or accident insurance or assistance plan. Submission must be first made to such carriers.

Medical Incident

Name: _____ Date of sickness or injury: ____/____/____

Location (City and Country):_____

Nature of Sickness or injury and course of action:

Physician or Hospital:

_____

_____

******Remember to tell team members to keep invoices and receipts of doctor and hospital bills, and prescriptions.***

If a team member loses checked baggage from the airlines and they will submit a claim, as a travel representative of your group, you can document the incident (but do everything possible to get a report from the AIRLINES, etc). Please notate time, place, and items lost. Your first course of action is to file a claim with the airline itself. This policy does not cover contents of baggage, nor loss from any place other than the airline. If you need extra baggage coverage, please call 1-800-576-2674 for other policy options.

When in doubt Call IMG!

The assistance line is available 24/7.
They will help you determine what documentation is needed in order to file a successful claim and help you through a medical emergency.

1-800-628-4664 or collect 01-317-655-4500

Claim Filing Instructions & Claim Form

INTERNATIONAL MEDICAL GROUP

Please follow these instructions prior to filing a claim and when completing the Claim Form. Assistance is also available from the International Medical Group® (IMG®) Customer Service Department at the telephone numbers listed below.

IF YOU HAVE NOT YET RECEIVED TREATMENT:

Pre-certification (notification of illness or accident):
You must call IMG to pre-certify any of the following conditions: any treatment requiring hospitalization; outpatient surgery, CAT scans, MRI's; within 48 hours after an emergency admission to the hospital; care in an extended care facility; home nursing care; durable medical equipment including artificial limbs; or transplants. Pre-certification may be done by you, a relative, or a hospital representative.

Independent Preferred Provider Organization (PPO): Your plan may recommend you receive treatment from a provider within the US PPO. You may access a listing of physicians or facilities by:

- Using the IMG website, ***www.imglobal.com***. This provides a complete listing of providers by specialty and geographic location.
- Contact the IMG Customer Service Department at the telephone number or mailing address listed below for a list of providers in your area. Please note, due to the size of the PPO network we can only send directories for your immediate area.

When receiving treatment from a PPO provider, please follow these instructions:

- Present your IMG medical identification card to the provider.
- Request that the provider send the bill directly to IMG. Please note, if you pay directly to the provider for an eligible expense this will likely affect your reimbursement from IMG. The negotiated fee for services will be the maximum reimbursement, whether paid to the provider or to you.
- Complete the Claim Form and submit it with all original bills or invoices. If the provider has filed the claims on your behalf, simply forward the completed Claim Form to IMG.
- When receiving treatment from a PPO provider for eligible expenses, the submitted bills must be re-priced through the PPO to the negotiated rate. This procedure may extend the normal processing time of your claim.

IF YOU HAVE ALREADY RECEIVED TREATMENT:

- If this is a new claim, complete *ALL PARTS* of the Claim Form. If treatment was received in the United States you do not need to complete PART C.
- If this is a continuing claim, complete PARTS A AND D. If treatment was received outside of the United States, you should also complete PART C.
- Attach all original itemized bills, statements and invoices for services and supplies.
- Please make certain that all documents indicate claimant's name, date of service, diagnosis and the itemized charges.

Mail the completed form to*:
International Medical Group, Inc.
Claims Department
P.O. Box 88500
Indianapolis, Indiana 46208-0500 USA

*Overnight packages should be sent to:
2960 North Meridian Street,
Indianapolis, IN 46208

For additional assistance:
Phone: 1-800-628-4664 (In US) 1-317-655-4500 (Outside US)
Fax: 1-317-655-4505
Email: insurance@imglobal.com Web: www.imglobal.com

Our goal at IMG is to process your claim quickly, accurately and efficiently. In order to achieve this, the Claim Form must be fully and accurately completed. Failure to do this will result in processing delays.

Claim Form & Authorization

INTERNATIONAL MEDICAL GROUP

DIRECTIONS FOR SUBMITTING A CLAIM
(There are four parts to this form – A, B, C & D. Please carefully review the instructions below.)

- If this a new claim, complete ALL PARTS of this form. If treatment was received in the United States you do not need to complete PART C.
- If this is a continuing claim, complete PARTS A AND D. If treatment was received outside of the United States, you should also complete PART C.
- Attach all original itemized bills, statements and invoices for services and supplies.
- Please make certain that all documents indicate claimant's name, date of service, diagnosis and the itemized charges.
- **Mail to:** **International Medical Group, Inc.**
  Claims Department
  P.O. Box 88500
  Indianapolis, Indiana 46208-0500 USA
  Phone: 800.628.4664 or Outside US 317.655.4500

Notice: Any false statement, concealment or fraud shall render this insurance null and void and all claims hereunder shall be forfeited.

PART A. To be completed and signed by the Claimant for all claims.

Claimant/Patient Name: (as appears on ID card)		
☐ Male ☐ Female	Date of Birth: mo /day /yr	
Claimant's Relationship to Primary Insured ☐ Self ☐ Spouse ☐ Child ☐ Other		
Name of Primary Insured: (as appears on ID card)		
☐ Male ☐ Female	Date of Birth: mo /day /yr	
Home Country Address:		
Current Address:		
Home Phone:	Work Phone:	E-mail:
Group # :	ID # :	
Are you in school full-time? ☐ Yes ☐ No		
If yes, please provide name of school and the address:		
Are you a U.S. Citizen? ☐ Yes ☐ No		
How many months of the year are you in the U.S.?		

If Claimant is covered by another plan, complete items below.

Name of Primary Insured: (as appears on ID card)		Date of Birth: mo /day/yr
Group # of other plan :	ID # of other plan :	
Mailing address	Name of other carrier	
City	Carrier address	
State / Postal Code	City	
Name of employer	State	Postal Code

PART B. To be completed by the Claimant for new claims only. (If you need additional space, please attach a separate sheet.)

1. How did the condition begin? State fully all symptoms and describe the condition in detail from the beginning. For accidents, include how, when and where the accident occurred.

mo / day / yr

2. When did the first symptom of this condition begin? State the exact date if possible.

3. Have you ever had or been treated for this type of injury or illness before? ☐ Yes ☐ No

4. List all the names and addresses of the providers you have seen for this condition.

5. What ailments, diseases, illnesses or injuries have you experienced during the last five years? Please provide the name and/or description of each condition, dates and name and address of the attending physician(s).

6. Is this condition the result of an accident or illness:

a. Related to employment? ☐ Yes ☐ No
If yes, are you applying for Worker's Compensation benefits? ☐ Yes ☐ No

b. Involving a motor vehicle? ☐ Yes ☐ No
If yes, please list the names of involved parties, insurance carriers and policy numbers.

c. Was a police report filed? ☐ Yes ☐ No
If yes, please identify the Police Department where it was filed.

PART C. Complete for all treatment received outside of the United States.

Date of service *mm/dd/yr*	Provider	What type of service and/or name of drug provided?	What was the illness/injury?	City/ country	Type of currency paid or billed	Total charge paid or billed	Converted to US funds	Office use only

PART D. Authorization - to be completed by the Claimant *for all claims.* *This section must be signed by hand.*

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 months from the date signed.

Print Name of Insured

Signature of Insured/Guardian_____ Date

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

PRIVACY AND CONFIDENTIALITY RELEASE FORM

By completing this form, you are providing your consent to IMG to discuss your claim activity with the person(s) listed below. Without this release form, IMG cannot discuss your claims activity with anyone other than your physician(s) or provider(s) of service. **This section must be signed by hand.**

I authorize IMG to discuss my claim activity with .
This authorization is valid for months from the date signed.

I give IMG permission to release any or all of the following information:

(Please select and initial)

☐ All financial and claim information related to medical bills or Claimant's Statement and Authorization.

☐ Provider name, date of service, total charge, total paid and date of payment.

☐ Insurance ID number and/or social security number.

Under no circumstances can IMG release medical information obtained from your physician or provider of service to you or anyone. Your medical information has been disclosed to us from your physician or provider of service and we are prohibited by federal law for further disclosure. Please contact your physician or provider of service for your medical information.

Print Patient Name Insurance ID Number

_____

Signature of the Patient or Insured Person if the patient is a minor child

Date

Please provide your current mailing address:

Street Address	
City	State, Country, Postal Code

Mail or fax to: **Claims Department**
International Medical Group
P.O. Box 88500
Indianapolis, IN 46208-0500
Telephone: 317-655-4500
Fax: 317-655-4505