

WORK & WITNESS - GLOBAL INSURANCE APPLICATION

For all teams traveling outside their country of citizenship.



Date: / / Team Name: Team Coordinator: Email:

Destination Country: Project Name: Dates of Travel: / / to / /

NAME	ADDRESS <i>ZIP CODE IS NECESSARY</i>	TELEPHONE NUMBER	DATE OF BIRTH	EMAIL ADDRESS	COUNTRY OF CITIZENSHIP
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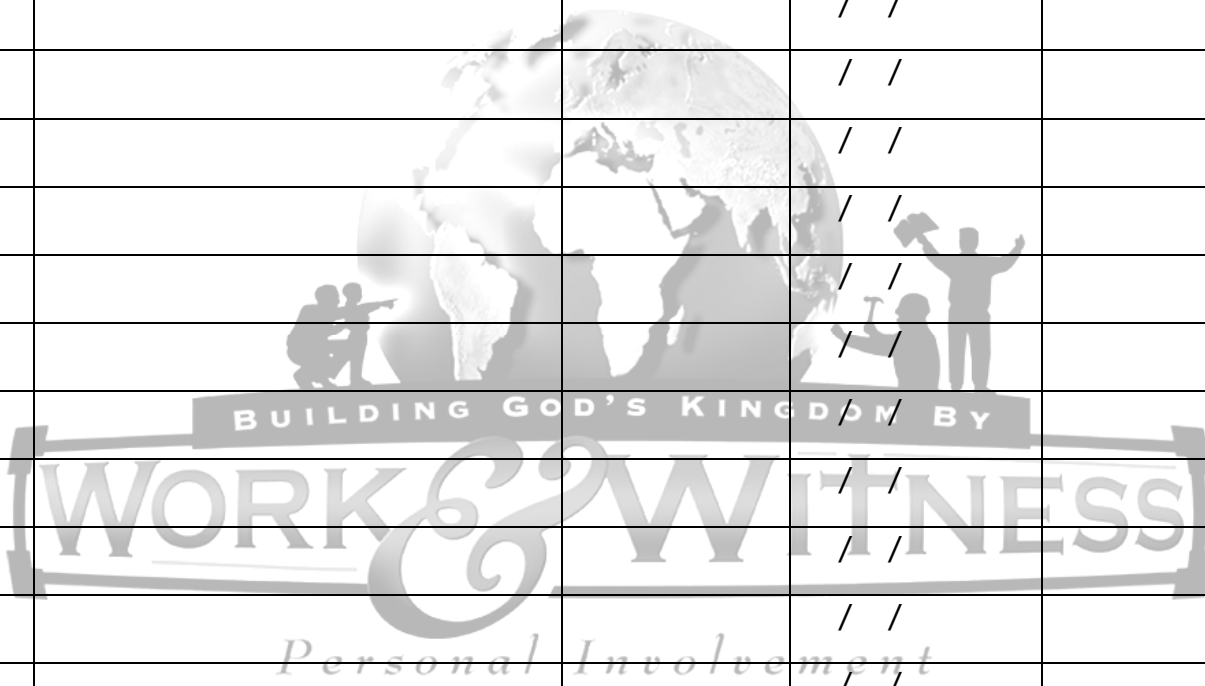




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**For assistance and information
please contact:**

Mission Personnel

~Visitors

~Work & Witness

~Mission Corps

17001 Prairie Star Parkway

Lenexa, KS 66220

913-577-0500

SUMMARY OF PLAN DESCRIPTION

Policy Number: 901 84 67-A

ELIGIBILITY

Class I: All registered participants of the Church of the Nazarene, including authorized family and other visitors to the field, while traveling outside of their country of permanent residence.

Class II: All registered participants of the Church of the Nazarene who, prior to their temporary return to their visit to their country of permanent residence, make a documented request with the Policyholder to have their coverage under this policy extended to include their entire temporary visit. The temporary return visit must be less than ninety days in total duration.

Class III: All registered participants of the Church of the Nazarene, including authorized family and other visitors to the field, while traveling outside of their country of permanent residence; upon review and approval by the Policyholder of an existing policy; may be authorized to purchase a limited or partial portion of the policy through the Church of the Nazarene.

BENEFITS

ACCIDENT & SICKNESS MEDICAL EXPENSES (Applicable to Classes I,II only)

BENEFIT MAXIMUM \$100,000

The Company will pay benefits with respect to covered expenses, resulting from a disablement. Coverage is limited to covered expenses incurred subject to the limitations shown in the Exclusions section. The term "disablement" as used with respect to medical expenses

shall mean an illness or an accidental bodily injury necessitating medical treatment by a physician as defined in the policy. All bodily injuries sustained in any one accident shall be considered one disablement; all bodily disorders existing simultaneously which are due to the same or related causes shall be considered one disablement. If a disablement is due to causes which are the same or related to the cause of a prior disablement (including complications arising there from), the disablement shall be considered a continuation for the prior disablement and not a separate disablement. Initial treatment of a disablement must occur during the period of coverage.

SCHEDULE OF BENEFITS

When a covered injury or illness occurs, the Company will pay for:

In Hospital Medical Services	100% of covered expenses
In Hospital Surgical Services	100% of covered expenses
Out of Hospital Medical Expenses	100% of covered expenses

In no event shall the Company's maximum liability exceed \$100,000 as to covered expenses during any one period of individual coverage.

The plan will pay 100% up to the maximum amount stated.

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Covered Expenses are the regular and customary charges for services and supplies incurred as the result of and within 26 weeks from the date of the disablement. They include: **(a)** charges made by a hospital for room and board, floor nursing and other services, including charges for professional services, except personal services of a non-medical nature, provided, however, that expenses do not exceed the hospital's average charge for semi-private room and board accommodation; **(b)** charges made for diagnosis, treatment and surgery by a physician; **(c)** charges made for the cost and administration of anesthetics; **(d)** charges for medication, x-ray services, laboratory tests and services, the use of radium and radio-active isotopes, oxygen, blood transfusions, iron lungs, and medical treatment; **(e)** charges for physiotherapy, if recommended by a physician, for treatment of a specific disablement and administered by a licensed physiotherapist; **(f)** hotel room charge, when the insured person, otherwise necessarily confined in a hospital, shall be under the care of a duly qualified physician in a hotel room owing to unavailability of a hospital room by reason of capacity or distance or to any other circumstances beyond the control of the insured person; **(g)** dressings, drugs, and medicines that can only be obtained upon written prescription of a physician or surgeon.

EXCLUSIONS

With respect to Accident and Sickness Medical Expenses, no benefits shall be payable with respect to expenses incurred:

(1) Pre-Existing conditions, defined as any injury or illness which was contracted or which manifested itself, or for which treatment or medication was prescribed **twelve (12) months prior** to the Insured's effective date of coverage;

(2) For services, supplies or treatment, including any period of hospital confinement, which were not recommended, approved and certified as necessary and reasonable by a physician;

(3) For suicide or any attempted threat while sane or self-destruction or any attempted threat while insane;

(4) Declared or undeclared war or any act thereof;

(5) For injury sustained while participating in professional athletics;

(6) For routine physicals or other examinations where there are no objective indications or impairment in normal health, and laboratory diagnostic or X-ray examinations except in the course of a disability established by the prior call or attendance of a physician;

(7) For cosmetic or plastic surgery, except as the result of an accident;

(8) For elective surgery which can be postponed until the Insured returns to his/her country of residence;

(9) For any mental and nervous disorders or rest cures;

(10) For dental care, except as the result of injury to natural teeth caused by accident;

(11) For eye infractions or eye examinations for the purpose of prescribing corrective lenses for eyeglasses or for the fitting thereof, unless caused by accidental bodily injury incurred while insured hereunder;

(12) In connection with alcoholism and drug addiction, or use of any drug or narcotic agent;

(13) For congenital anomalies and conditions arising out of or resulting therefrom;

(14) For expenses which are non-medical in nature;

(15) For the ordinary cost of a one-way airplane ticket used in the transportation back to the Insured's country where an air ambulance benefit is provided;

(16) For expenses as a result of or in connection with intentionally self-inflicted injury;

(17) For expenses as a result of or in connection with the commission of a felony offense;

(18) For specific named hazards: Scuba diving, skiing, mountain climbing, sky diving, professional or amateur racing, piloting an aircraft, or other activities deemed as hazardous;

(19) Treatment paid for or furnished under any mandatory government program or facility set up for treatment without cost to any individual.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (Applicable to Class I and II)

PRINCIPAL SUM: \$75,000

When injury results in any one of the following losses to an insured person within 365 days of the date of the covered accident, which caused the injury, the Company will pay the Principal Sum applicable as stated below:
Description of Loss Indemnity

For Loss of:

- Life. Principal Sum
- Both Hands or Both Feet or
- Sight of Both Eyes. Principal Sum
- One Hand and One Foot. Principal Sum
- Either Hand or Foot and
- Sight of One Eye. Principal Sum
- Either Hand or Foot. . . One-Half of the Principal Sum
- Sight of One Eye. . . . One-Half of the Principal Sum
- Quadriplegia. Principal Sum
- Paraplegia. Three Quarters of the Principal Sum
- Hemiplegia. One-Half of the Principal Sum
- Uniplegia. One-Quarter of the Principal Sum

"Loss" means with regard to hand or foot, actual severance through or above the wrist or ankle joint; and with regard to eye, entire and irrecoverable loss of sight, with reference to quadriplegia, paraplegia, and hemiplegia, means the complete and irreversible paralysis of such limbs. Only one benefit, the largest to which the Insured Person is entitled, will be paid for the losses resulting from the same accident.

AGGREGATE LIMIT OF LIABILITY

The Aggregate Limit of Indemnity shall be the total limit of the Company's liability for all indemnities payable under Accidental Death and Dismemberment Indemnity with respect to Insured Persons arising out of injury sustained by two or more Insured Persons as the result of any one accident.

If the total of such indemnity exceeds said Aggregate Limit of Indemnity, the Company shall not be liable to any one such Insured Person for a greater proportion of such Insured Person's Indemnity afforded by the Accidental Death and Dismemberment Indemnity than said Aggregate Limit of Indemnity bears to the total indemnities afforded by this Accidental Death and Dismemberment Indemnity to all such Insured Persons.

Policy Aggregate Limit: \$375,000 per occurrence

EMERGENCY EVACUATION (Applicable to All Classes)

BENEFIT MAXIMUM \$100,000

Emergency Evacuation must be coordinated through AIU Holdings Travel Assist [See *Note with instructions on page 18]. The Company will pay benefits for Covered Expenses incurred up to the maximum of \$100,000 if an injury or illness commencing during the course of a trip results in the necessary emergency evacuation of the Insured Person. An emergency evacuation must be ordered by a legally licensed physician who certifies that the severity of the Insured Person's injury or sickness warrants the emergency evacuation of the Insured Person.

Emergency Evacuation means: **a)** the Insured Person's medical condition warrants immediate transportation from the place where the Insured Person is injured or sick to the nearest hospital where appropriate medical treatment can be obtained; or **b)** after being treated at a local hospital, the Insured Person's medical condition warrants transportation to the place where he or she resides

(except if the insured has been maintaining a residence elsewhere with his or immediate family) to obtain further medical treatment or to recover; or **c**) both a) and b) above.

Covered Expenses are expenses, up to the maximum, for transportation, medical services and medical supplies necessarily incurred in connection with emergency evacuation of the Insured Person. All transportation arrangements made for evacuating the insured person must be by the most direct and economical route. Expenses for special transportation must be: **(a)** recommended by the attending physician; or **(b)** required by the standard regulations of the conveyance transporting the insured person. Expenses for medical supplies and services must be recommended by the attending physician. Transportation means any land, water or air conveyance required to transport the insured person during an emergency evacuation. Special transportation includes, but is not limited to, air ambulances, land ambulances, and private motor vehicles.

REPATRIATION OF REMAINS (Applicable to All Classes)

BENEFIT MAXIMUM \$25,000

Repatriation must be coordinated through AIU Holdings Travel Assist [See *Note with instructions on page 18]. The Company will pay the reasonable covered expenses incurred to return the insured person's body home (to his/her Home Country) if he or she dies during the course of the trip not to exceed the maximum benefit amount of \$25,000.

Covered Expenses include, but are not limited to, expenses for embalming, cremation, coffins and transportation.

With regard to Emergency Evacuation and Repatriation of Remains, **1)** Exclusions 2, 3, & 4 of the Accidental Death and Dismemberment Exclusions section shall not apply. **2)** Expenses, which are incurred by an Insured

Person, shall apply only while outside his/her home or regular place of employment and which are coordinated through AIG Travel Assist. **3)** The term "Sickness" as used herein means sickness or disease which causes a covered loss for which symptoms are manifested while the policy is in force as to the Insured Person whose sickness is the basis for claim.

SEAT BELT AND AIR BAG BENEFIT (Applicable to All Classes)

Seat Belt Benefit. An Additional Accidental Death Benefit of 10% will be paid, to a maximum of \$15,000, if an Insured Person's death results from operating or riding as a passenger in a private passenger type automobile designed for use primarily on public roads and his/her originally equipped, factory installed, unaltered, seat belt or lap and shoulder restraint, is properly fastened at the time of loss.

Air Bag Benefit. An additional benefit will be paid if a Seat Belt Benefit is payable under the Policy and if the Insured Person is positioned in a seat protected by a properly functioning, original, factory-installed Supplemental Restraint System that inflates on impact. The additional amount payable is the lesser of: **(1)** \$15,000; or **(2)** 10% of the Insured Principal Sum.

Verification of actual use of the seat belt, at the time of the accident, and that the Supplemental Restraint System inflated properly upon impact must be a part of an official report of the accident or be certified, in writing, by the investigating officer(s). The Insured Person must have died as a result of a "Covered Accident."

Automobile – means a self-propelled private passenger motor vehicle with four or more wheels, which is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, or jeep-type vehicle and, if not used primarily for occupational, professional or business purposes, a motor vehicle of the pickup, panel, van, camper or motor home type.

Automobile does not include a mobile home or any motor vehicle, which is used in mass or public transit.

Supplemental Restraint System –means an air bag, which inflates for added protection to the head and chest areas.

No benefit will be paid if the Insured Person was involved in the commission of, or attempt to commit a crime or felony, of if the Insured Person was under the influence of alcohol or any drug or narcotic unless administered on the advice of a qualified licensed physician.

SECURITY EVACUATION (SERVICES ONLY) (Applicable to All Classes)

The Company will pay benefits for Covered Expenses incurred up to the maximum of \$100,000 if, as a result of an Occurrence that takes place during an Insured Person's Period of Coverage and while traveling outside of his or her Home Country, an Insured Person requires a Security Evacuation, the Company will pay benefits to Transport the Insured Person to the Nearest Place of Safety. The determination that an Insured Person requires a Security Evacuation must be made by a Designated Security Consultant and all arrangements must be made by American International Assistance Services, Inc., (AIAS). If in the United States or Canada call 1-800-626-2427; if outside the United States or Canada call 0-713-267-2525.

Benefits will be payable for Transportation and Related Costs within 7 days of the Security Evacuation to either of these locations as chosen by the Company:

- 1) back to the Host Country if return is safe and permitted; or
- 2) the Insured Person's Home Country; or
- 3) where the Insured Person is currently permanently assigned by the Policyholder

Right of Recovery – If, after a Security Evacuation is completed, it becomes clear that the Insured Person was

an active participant in the events that led to an Occurrence, the Company has the right to recover all Transportation and Related Costs from the Insured Person.

Excess Provision – Benefits payable for the eligible expenses will be limited to that part of the eligible expense, if any, which is in excess of the total benefits for the same Security Evacuation under any other valid and collectible insurance or other indemnity. If other valid and collectible insurance or indemnity provides benefits on an excess coverage basis, benefits will be paid first by the insurer or services plan whose coverage has been in effect for the longer period of time at the date of the Security Evacuation.

Advisory means a formal recommendation by the Appropriate Authorities that the Insured Person or citizens of his or her Home Country or citizens of the Host Country leave the Host Country.

Appropriate Authority(ies) means the government authority(ies) in the Insured Person's Home Country or the government authority(ies) of the Host Country.

Designated Security Consultant means an employee of a security firm under contract with AIAS or an AIAS designated service provider who is experienced in security provider who is experienced in security and measures necessary to ensure the safety of the Insured Person(s) in his or her case.

Excluded Countries means the following Countries from which Security Evacuations are not available are: Iraq, Afghanistan, Pakistan, Israel (West Bank and Gaza Strip) Iran, Chechnya or any country subject to the administration and enforcement of U.S. economic embargoes and trade sanctions by the OFFICE OF FOREIGN ASSETS CONTRAL (OFAC).

Home Country means the country of citizenship of the Insured Person. If the Insured has dual citizenship, his or her Home Country is the country of the passport he or she used to enter the Host Country.

Host Country means any country, other than an Excluded Country, in which an Insured Person is traveling while covered under the Policy.

Imminent Physical Danger means the Insured Person is subject to possible physical injury or sickness that could result in grave physical harm or death.

Missing Person means an Insured Person who disappeared for an unknown reason and whose disappearance was reported to the Appropriate Authority(ies).

Nearest Place of Safety means a location determined by the Designated Security Consultant where:

1. the Insured Person can be presumed safe from the Occurrence that precipitated the Insured Person's Security Evacuation; and
2. the Insured Person has access to transportation; and
3. the Insured Person has the availability of temporary lodging, if needed.

Occurrence means any of the following situations in which an Insured Person finds him or her self while covered by the Policy:

1. expulsion from a Host Country or being declared persona non-grata on the written authority of the recognized government of a Host Country;
2. political or military events involving a Host Country, if the Appropriate Authorities issue an Advisory stating that citizens of the Insured Person's Home Country or citizen's of the Host Country should leave the Host Country;
3. Verified Physical Attack or a Verified Threat of Physical Attack from a third party

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WAR RISK (Applicable to All Classes)

Such insurance as is afforded an Insured Person to which this benefit applies shall apply only to injury as defined in the Definitions, caused by or resulting from declared or undeclared war or any act thereof occurring within the following territory:

Worldwide, excluding the United States, and the Insured Person's country or permanent residence.

Such insurance as is afforded by this benefit shall be subject to the following conditions:

1. It shall automatically terminate upon the occurrence of war among the major powers of Europe or Asia.
2. The premium for this insurance and the benefits and the territorial are of coverage provided thereby (or any one or more of them) may be revised by agreement between the Company and the Policyholder at any time or from time to time as may be necessary to reflect conditions which in the opinion of the Company or the Policyholder constitute a change in the war risk exposure.

EXCLUSIONS

With respect to Accidental Death and Dismemberment Expenses, Emergency Evacuation and Repatriation of Remains, no benefits shall be payable with respect to expenses incurred:

- (1) Suicide or any attempted threat while sane or self destruction or any attempted threat while insane;
- (2) Disease of any kind;
- (3) Bacterial infections except pyogenic infection, which shall occur through an accidental cut or wound;
- (4) Hernia of any kind;

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(5) Injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as otherwise provided. See Description of Coverage Section;

(6) Service in the military, navel or air service of any country;

(7) Being under the influence of drugs or intoxicants, unless taken under the advice of a physician;

(8) Committing or attempting to commit a felony;

(9) Flying in any aircraft being used for or in connection with acrobatic or stunt flying, racing or endurance tests;

(10) Flying in any rocket-propelled aircraft;

(11) Flying in any aircraft being used for or in connection with crop dusting or seeding or spraying, fire fighting, exploration, pipe or power line inspection, any form of hunting, bird or fowl herding, aerial photography, banner towing or any test or experimental purpose, unless previously consented to in writing by the Company.

(12) Flying in any aircraft, which is engaged in any flight, which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted, unless previously consented to in writing by the Company.

DESCRIPTION OF COVERAGE

Coverage is provided during the course of a trip sponsored by the Policyholder.

Such trip shall be deemed to have commenced when the insured person leaves his/her country of permanent residence for the purpose of going on such trip, and shall continue until such time as he/she returns to his/her country of permanent residence.

Such insurance includes such injury sustained during such trip while the insured person is riding as a passenger (but not as a pilot, operator or member of the crew) in or on, boarding or alighting from:

(1) any civilian aircraft having a current and valid airworthiness certificate, and piloted by a person who then holds a valid and current certificate of competency of a rating authorizing him/her to pilot such aircraft; or

(2) any transportation type aircraft operated by the Military Airlift Command (MAC) of the United States, or by the similar air transport service of any duly constituted governmental authority of any other recognized country;

provided that this coverage shall not apply while such insured person is riding in any civilian or military aircraft other than as expressly described herein, unless previously consented to in writing by the Company.

POLICY PROVISIONS

Notice of Claim: Written notice of claim must be given to the Company within twenty days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the Administrative Offices of the Company, or to any authorized agent of the Company, with information sufficient to identify the Insured Person shall be deemed notice to the Company.

Claim Forms: The Company, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to the Company at its said office in case of claim for loss for which the policy provides any periodic payment content upon continuing loss within ninety days after the termination of the period for which the Company is liable

and in case of claim for any other loss within ninety days after the date of such loss.

Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

Time of Payment Claims: Indemnities payable under the policy for any loss other than loss for which the policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which the policy provides periodic payment will be paid at the expiration of each four weeks during the continuance of the period for which the Company is liable, and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed therein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Insured Person. Any accrued indemnities unpaid at the Insured Person's death may, at the option of the Company, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Insured Person.

If any indemnity of the policy shall be payable to the estate of an Insured Person, or to an Insured Person who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding \$1,000, to any relative by blood or connection by marriage of the Insured Person who is deemed by the Company to be equitable entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

Subject to any written direction of the Insured Person all or a portion of any indemnities provided by the policy on account of hospital, nursing, medical or surgical service may, at the Company's option and unless the Insured Person requests otherwise in writing not later than the time for filing proof on such loss, be paid directly to the hospital or person rendering such services, but it is not required that the service be rendered by a particular hospital or person.

Physical Examination and Autopsy: The Company at its own expense shall have the right and opportunity to examine the person or any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder, and to make an autopsy in case of death, where it is not forbidden by law.

Legal Actions: No actions at law or in equity shall be brought to recover on the policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of the policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Conformity With State Statutes: Any provision of the policy, which on its effective date, is in conflict with the statutes of the state in which the policy was delivered or issued is hereby amended to conform to the minimum requirements of those statutes.

NOTE: This is only a brief description of the benefits of this plan. The policy shall provide the only basis for coverage and claim.

HOW TO FILE A CLAIM

A. Obtain the appropriate claim form.

B. For medical claims, all medical bills must be itemized and clearly indicate:

- the patient's name
- diagnosis
- type of treatment
- date of service
- charges made by the provider for services rendered.

C. Mail the completed and signed claim form to:

Mission Personnel

Church of the Nazarene
17001 Prairie Star Parkway
Lenexa, KS 66220

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ASSISTANCE SERVICES

The following services are available to you on a 24-hour basis when you travel a distance of 100 miles or more away from your primary residence or permanent place of assignment.

• **Medical Assistance:** includes locating medical facilities, physicians; verify insurance coverage; communicating with family members and personal physician.

• **Emergency Medical Evacuation/Repatriation**

Services: Qualified physicians are on hand 24 hours a day to consult with local attending physicians, ensuring proper medical treatment. Should evacuation to an alternative medical facility be deemed medically necessary, arrangements will be made for air and land transportation, including passage on an air ambulance by a qualified staff member. A qualified staff member will also make arrangements for the repatriation of the deceased.

• **Legal Assistance:** Legal council is available to any covered traveler who may be arrested for a noncriminal action. Other legal services, which include finding English-speaking attorneys or replacing lost or stolen documents, are also available.

***Note: Before obtaining Medical / Security Evacuation or Repatriation Assistance call**
If in the United States or Canada call
1-800-626-2427
If outside the United States or Canada call
0-713-267-2525

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Please note that most countries will insist you make payment at the time of treatment. For any amounts under \$500.00 USD, the individual or team is expected to cover these charges. For larger sums, the Field or Regional office **may be able to** assist you with payment.

If at any time an individual is hospitalized contact our office as soon as possible.

Mission Personnel
Church of the Nazarene
During Business Hours: 913-577-5000 ext 2953
After Business Hours or Weekends: 816-699-5420

**AIU Holdings Travel Assist
Identification Card
INTERNATIONAL SERVICES, INC.**
POLICY NUMBER: 1190-901 84 67-A
GROUP: **Church of the Nazarene**
PARTICIPANT:

Signature

GLOBAL INSURANCE PROGRAM

Designed For:

CHURCH OF THE NAZARENE

Underwritten By:

THE INSURANCE COMPANY

OF THE

STATE OF PENNSYLVANIA

A Capital Stock Company

Incorporated, 1794

Philadelphia • PA

Accident & Health, a division of

AIU Holdings, Inc.

The person named is eligible for certain Services and Benefits as outlined in the Service Agreement provided to the Group. Before obtaining medical and non-medical Assistance, call the nearest office below. If necessary, call collect.

If in the United States or Canada call

1-800-626-2427

If outside the United States or Canada call

0-713-267-2525

WORLDWIDE COVERAGE



GLOBAL POLICY

Attached is a copy of the claim form requested. Please read the following instructions carefully as the below information is required in order to begin processing your claim.

Each person filing a claim will need to submit a separate claim form. Page "A" must have all sections completed in detail. Please ensure the claim form is signed where indicated as no claims can be processed without the claim form being completed in its entirety. Please pay careful attention to the instructions located at the top of the claim form. Failure to follow these instructions will delay the claims process.

Medical claims:

Claims for care provided within the United States of America must submit documentation on itemized insurance billing forms prepared by the medical provider or facility where treatment/services were rendered. A medical provider will provide a HCFA1500 Form and a facility (hospital) will provide a UB92 form. Balance due statements from medical providers are not acceptable.

When this is not available for treatment received outside your country of permanent residence, the following is needed in lieu of Side "B" and must include:

- Participant name
- Physician/Provider name
- Physician signature
- Date service provided
- Type of service provided
- Diagnosis
- Cost in local currency

Processing: Once the claim package is received, it will take approximately 30 - 45 business days to review and process your claim. Please keep in mind that all decisions regarding claims will be made by the Claims Department and will be based on the documentation provided when the claim is filed.

Exchange Rates: To provide consistency the approved exchange rate resource is www.oanda.com. All claims are reimbursed in US Dollars. When calculating the USD equivalent it is important to use the date the service was provided instead of the date payment was made. If you incur additional fees for processing, wire transfers, or late fees, these are not reimbursable by the carrier. Contact the Mission Personnel office team with any questions related to filing a claim missionservices@nazarene.org or refer to the Global Policy pamphlet on line.

Mail completed form to: Global Mission Personnel
17001 Prairie Star Parkway
Lenexa KS 66220
Or fax to: 913-577-0889

NAME OF GROUP: **Church of the Nazarene**

POLICY NUMBER: **9018467**

**For hospitalizations or emergencies call:
913-577-2953 during business hours
816-699-5420 after hours or weekends**

Circle one: W&W/YIM/Mission Corps/other approved visitor

ACCIDENT AND SICKNESS CLAIM FORM/ GLOBAL

INSTRUCTIONS:

1.) This form is to be used when filing a claim for reimbursement of Medical Expenses.

2.) Section A must be completed by the Insured in full.

3.) One of the following must be provided:

- Fully Completed Medical Form by the Attending Physician, and/or
- Fully Itemized Bills from treatments center showing Claimant's Name, Nature of Illness/Injury, Description and Charge for each service.

4.) This form must be signed and dated in all applicable sections.

5.) This form and all attached bills must be submitted to the address indicated above.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SIDE A

Coverage Start Date _____/_____/_____ Coverage Termination Date: _____/_____/_____ Dates of coverage are the dates of your travel.

NEW 7/1/2010: SS# required: _____-____-_____

1.) Name of Claimant: _____ Claimant's Date of Birth: _____/_____/_____ Gender: Male Female

2.) Current Residence/Address: _____

3.) Date of arrival in U.S.: _____/_____/_____ Daytime phone number: _____ (____) _____

4.) Permanent Address (In Home Country): _____

5.) If injury, give date injury occurred and details of the injury/accident: _____

6.) If Illness, advise when and where symptoms first occurred: _____ Country _____ Date _____
Please indicate nature of the illness and/or describe your symptoms: _____

7.) Have you been treated for this illness or injury prior to the effective date of this insurance? _____
If yes, provide name and address of the treating Physician(s) and date(s) first consulted. _____

8.) Provide Name and Address of your Regular Physician in your Home Country: _____

9.) Were you taking any medications prior to the effective date of this insurance? _____ If yes, please provide the following:

Drug Name: _____ Drug Name: _____ Drug Name: _____

Prescribed for: _____ Prescribed for: _____ Prescribed for: _____

Physician Name: _____ Physician Name: _____ Physician Name: _____

Date 1st Prescribed: _____ Date 1st Prescribed: _____ Date 1st Prescribed: _____

11.) Do you have other health insurance? Yes _____ No _____ If yes, please provide the name, address and policy number of the Insurance: _____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I authorize payment of medical benefits to the physician or supplier for service performed. YES NO

Optional Limited Assignment

I hereby make a limited assignment to _____ (my "Assignee") of the right to receive the benefits due for those covered medical expenses incurred by me and actually paid directly to the provider of those services by my Assignee. I understand that the Company bears no responsibility or liability for the validity or effect of this assignment or for any payments made by the Company prior to receipt of satisfactory proof of payment by the Assignee. I hereby specifically release, and agree to indemnify, the Company from any and all liability incurred for any such payments made.

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."

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 containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company 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 value of the subject motor vehicle or stated claim for each violation.

For residents of Pennsylvania: 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 and subjects such person to criminal and civil penalties."

For claimants not residing in California, New York, or Pennsylvania: 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.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE: _____

DATE: _____

SIDE B - Health Insurance Claim Form / Global

CLAIMANT INFORMATION

1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (ID)	MEDICAID <input type="checkbox"/> (Medicaid #)	CHAMPUS CHAMPVA GROUP HEALTH PLAN <input type="checkbox"/> (Sponsor's SSN)	FECA BLK LUNG <input type="checkbox"/> (VA File #) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (SSN)	1a. Claimant Soc Sec Number
---	---	---	---	-----------------------------

2. PATIENT'S NAME (First Name, Middle Initial, Last Name)	3. PATIENT'S DATE OF BIRTH MM / DD / YY	SEX M <input type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (First Name, Middle Initial, Last Name)
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5. PATIENT'S ADDRESS (No., Street)	6. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/> (SPECIFY)	7. INSURED'S ADDRESS (No., Street)
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CITY	STATE	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	CITY	STATE
ZIP CODE	TELEPHONE NO. ()	Employed <input type="checkbox"/> Full Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	ZIP CODE	TELEPHONE NO. ()

9. OTHER INSURED'S NAME	10. IS PATIENT'S CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> C. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> D. RESERVED FOR LOCAL USE	11. INSURED'S POLICY GROUP OR FECA NUMBER
A. OTHER INSURED'S POLICY OR GROUP NUMBER		3. PATIENT'S DATE OF BIRTH MM / DD / YY
B. OTHER INSURED'S DATE OF BIRTH MM / DD / YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>
C. EMPLOYER'S NAME OR SCHOOL NAME		B. EMPLOYER'S NAME OR SCHOOL NAME
D. INSURANCE PLAN NAME OR PROGRAM NAME		C. INSURANCE PLAN NAME OR PROGRAM NAME
		D. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to & complete item 9 A-D

12. PATIENT'S OR AUTHORIZED PERSONS' SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to undersigned physician or supplier for service described below.
Signature _____ Date _____	Signature _____ Date _____

14. DATE OF CURRENT: MM / DD / YY	ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: GIVE FIRST DATE: MM / DD / YY	16. Dates Patient Unable To Work in Current Occupation MM / DD / YY FROM: / / TO: / /
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17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. Hospitalization Dates Related to Current Services MM / DD / YY FROM: / / TO: / /
---	---	--

19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
1 _____ 3 _____	
2 _____ 4 _____	23. PRIOR AUTHORIZATION NUMBER

24. A	B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE FROM MM/DD/YY TO MM/DD/YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	DPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. BALANCE DUE \$
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31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office).	33. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE #
SIGNED _____ DATE _____		PIN# _____ GRP# _____

- | | | | |
|---|--|--|--|
| PLACE OF SERVICE CODES
1-(H) - INPATIENT HOSPITAL
2-(OH) - OUTPATIENT HOSPITAL
3-(O) - DOCTOR'S OFFICE | 4-(H)-PATIENT'S HOME
5- -DAYCARE FACILITY (PSY)
6- -NIGHT CARE FACILITY(PSY) | 7-(NH) NURSING HOME
8-(SNF)-SKILLED NURSING FACILITY
9- -AMBULANCE | O-(OL)-OTHER LOCATIONS
A-(IL)-INDEPENDENT LABORATORY
B- -OTHER |
|---|--|--|--|

WORK & WITNESS - USA Insurance APPLICATION

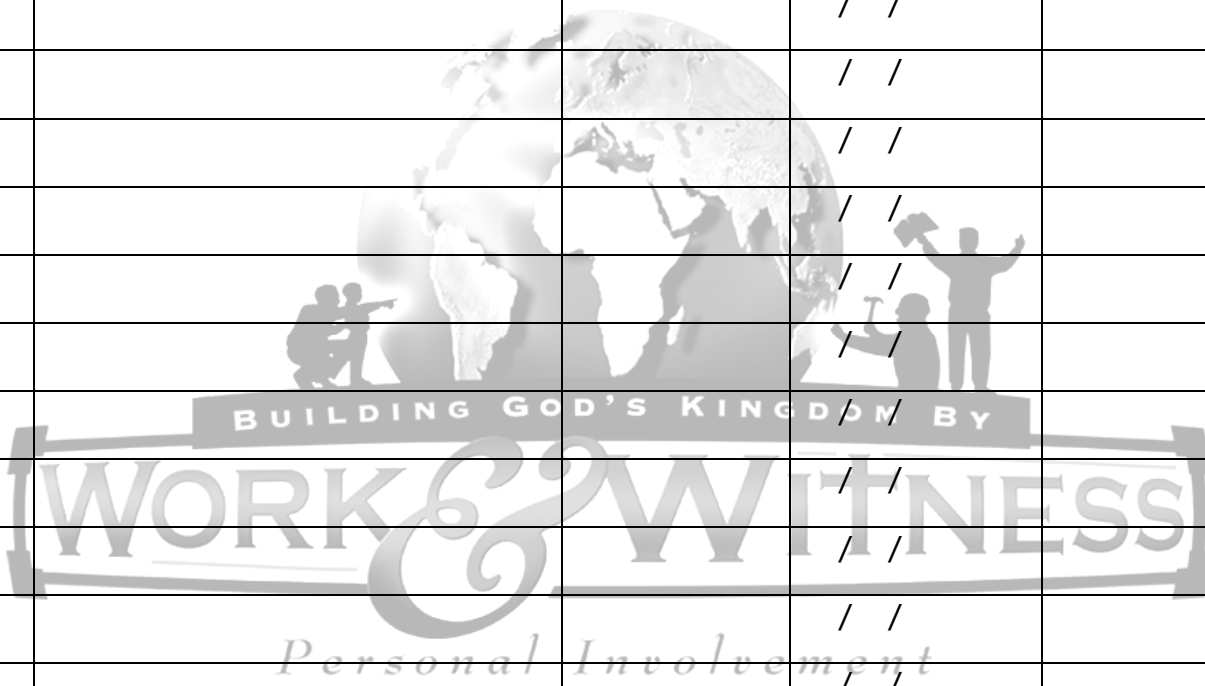
For USA teams traveling **within the USA ONLY.**



Date: / / Team Name: Team Coordinator: Email:

Destination Country: Project Name: Dates of Travel: / / to / /

NAME	ADDRESS <i>ZIP CODE IS NECESSARY</i>	TELEPHONE NUMBER	DATE OF BIRTH	EMAIL ADDRESS	COUNTRY OF CITIZENSHIP
TEAM COORDINATOR			/ /		
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National Union– USA Domestic Insurance Policy

Brief description of coverage limits

1. This policy will cover USA citizens or USA legal residents only.
2. This policy applies only when a USA citizen or legal resident is traveling within the 50 United States and Canada for the duration of their registered W&W trip.
3. This policy is an excess coverage policy.
4. Policy Limits – provides accidental injury coverage only- no illness coverage

<u>Accidental Death/ Dismemberment</u>	Maximum benefit is \$75,000.00 USD
<u>Accident Medical Expense</u>	Maximum benefit is \$75,000.00 USD
<u>Dental benefit</u>	Maximum benefit is \$1000.00 USD (if medically necessary)
5. No pre-existing conditions or hazardous acts are covered. Other exclusions apply.
6. Claimant must have proof of initial treatment occurred during the W&W trip.
7. We must receive notice of injury within 30 days.
8. All claims must be filed with personal insurance(s) and with this policy. A healthcare provider can contact the W&W office with any questions.
9. Contact our office for a claim form or send Explanation of Benefits with original receipts to:

W&W Church of the Nazarene
17001 Prairie Star Parkway
Lenexa, KS 66220
913-577-0500 x 2953

This is not a complete policy disclosure, but intended to provide basic information for general use only. Changes in the policy coverage may occur without notice.

**National Union Fire Insurance Company of
Pittsburgh, Pa.**

Work & Witness/Mission Corps

Global Ministries Center

17001 Prairie Star Parkway

Lenexa, KS 66220

913-577-0500 x 2953 fax 913-577-0889

PROOF OF LOSS

NAME OF GROUP: Church of Nazarene

POLICY NUMBER: 9110482

SPECIAL RISK -ACCIDENTAL INJURY CLAIM FORM

INSTRUCTIONS:

- 1.) **You must have SECTION A fully completed by a designated official of the Policyholder.**
- 2.) **SECTION B is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.**
- 3.) **Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service. PLEASE MAIL COMPLETED FORM AND BILLS TO ABOVE ADDRESS.**

PRIMARY PLAN - benefits are payable for covered medical expenses from the first dollar without regard to payments made by other insurance up to the policy maximum. EXCESS PLAN - Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You must submit your claim to your other insurance company first. When you receive their Benefit Statement (EOB) send it to us along with the itemized bills. Benefits for eligible expenses will be paid per policy terms.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A - MUST BE COMPLETED AND SIGNED BY A DESIGNATED REPRESENTATIVE OF THE POLICYHOLDER

NAME/ AND/OR LOCATION OF GROUP/CLUB/SPORT/SCHOOL, ETC.

Church of the Nazarene Work & Witness USA 6401 The Paseo Kansas City MO 64131

CLAIMANT'S FULL NAME (PLEASE PRINT CLEARLY OR TYPE)

SOCIAL SECURITY NO. (IF AVAILABLE)

DATE OF BIRTH

NAME OF SUPERVISOR

DATE COVERAGE BEGAN

DATE COVERAGE WILL END/HAS ENDED

NATURE OF INJURY OR ILLNESS. (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED.)

DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED (DATE AND TIME).

NAME OF ACTIVITY

DID ACCIDENT OCCUR:

A. WHILE CLAIMANT WAS SUPERVISED

YES

NO

B. DURING SPONSORED ACTIVITY

YES

NO

INDICATE THE SPORT (IF APPLICABLE)

C. DURING PROGRAMMED HOURS

YES

NO

D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP

YES

NO

POLICYHOLDER REPRESENTATIVE (PLEASE PRINT OR TYPE)
NANCY FIRESTONE

TITLE
WORK & WITNESS EXECUTIVE
ASSISTANT

DAYTIME TELEPHONE NUMBER
(816)333-7000 X 2330

SIGNATURE OF POLICYHOLDER REPRESENTATIVE

DATE

Approved signature will be added when the form is received in the W&W office

SECTION B - MUST BE COMPLETED

LIST NAME, ADDRESS, AND PHONE # OF OTHER INSURANCE COMPANIES UNDER WHICH CLAIMANT IS INSURED:

POLICY #/ACCOUNT #

IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN/RELATIONSHIP TO CLAIMANT

ADDRESS OF CLAIMANT (IF CLAIMANT IS A MINOR, NAME AND ADDRESS OF CLAIMANT'S GUARDIAN)

GUARDIAN'S SOCIAL SECURITY NUMBER

NAME/ADDRESS/TELEPHONE # OF EMPLOYER (IF CLAIMANT IS A MINOR, GUARDIAN'S EMPLOYER)

EMPLOYER'S DAYTIME TELEPHONE #

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I authorize payment of medical benefits to the physician or supplier for service performed. YES NO

This form is for claimants not residing in California, New York, or Pennsylvania: 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.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE

DATE

SECTION C - HEALTH INSURANCE CLAIM FORM

CLAIMANT INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS/CHAMPVA GROUP HEALTH PLAN (Sponsor's SSN) (VA File #) (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID) 1a. INSURED'S I.D. NUMBER

2. PATIENT'S NAME (First Name, Middle Initial, Last Name) 3. PATIENT'S DATE OF BIRTH MM / DD / YY SEX M F 4. INSURED'S NAME (First Name, Middle Initial, Last Name)

5. PATIENT'S ADDRESS (No., Street) 6. PATIENT'S RELATIONSHIP TO INSURED
 SELF SPOUSE CHILD OTHER (SPECIFY) 7. INSURED'S ADDRESS (No., Street)
 CITY STATE CITY STATE
 ZIP CODE TELEPHONE NO. () ZIP CODE TELEPHONE NO. ()

8. PATIENT STATUS
 Single Married Other
 Employed Full Time Student Part-Time Student

9. OTHER INSURED'S NAME 10. IS PATIENT'S CONDITION RELATED TO:
 A. OTHER INSURED'S POLICY OR GROUP NUMBER A. PATIENT'S EMPLOYMENT? YES NO
 B. OTHER INSURED'S DATE OF BIRTH MM / DD / YY SEX M F B. AN AUTO ACCIDENT? YES NO
 C. EMPLOYER'S NAME OR SCHOOL NAME C. OTHER ACCIDENT? YES NO
 D. INSURANCE PLAN NAME OR PROGRAM NAME D. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER A. PATIENT'S DATE OF BIRTH MM / DD / YY SEX M F
 B. EMPLOYER'S NAME OR SCHOOL NAME C. INSURANCE PLAN NAME OR PROGRAM NAME

D. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to & complete item

12. PATIENT'S OR AUTHORIZED PERSONS' SIGNATURE.
 I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
 Signature _____ Date _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE.
 I authorize payment of medical benefits to undersigned physician or supplier for service described below.
 Signature _____ Date _____

14. DATE OF CURRENT: MM / DD / YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: GIVE FIRST DATE: MM / DD / YY 16. Dates Patient Unable To Work in Current Occupation FROM: MM / DD / YY TO: MM / DD / YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN 18. Hospitalization Dates Related to Current Services FROM: MM / DD / YY TO: MM / DD / YY

19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? \$ CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)
 1 _____ 3 _____
 2 _____ 4 _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
 23. PRIOR AUTHORIZATION NUMBER

24. A		B	C	D		E	F	G	H	I	J	K
DATE(S) OF SERVICE FROM TO		Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	DPSDT Family Plan	EMG	COB	RESERVED LOCAL USE
MM/DD/YY	MM/DD/YY											

25. FEDERAL TAX I.D. NUMBER EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? YES NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements apply to this bill and are made a part thereof.)
 SIGNED _____ DATE _____

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office).
 33. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE #
 PIN# _____ GRP# _____

- PLACE OF SERVICE CODES
- 1-(H) - INPATIENT HOSPITAL
 - 2-(OH) - OUTPATIENT HOSPITAL
 - 3-(O) - DOCTOR'S OFFICE
 - 4-(H)-PATIENT'S HOME
 - 5- -DAYCARE FACILITY (PSY)
 - 6- -NIGHT CARE FACILITY(PSY)
 - 7-(NH) NURSING HOME
 - 8-(SNF)-SKILLED NURSING FACILITY
 - 9- -AMBULANCE
 - O-(OL)-OTHER LOCATIONS
 - A-(IL)-INDEPENDENT LABORATORY
 - B- -OTHER

If you have an standard UB-92 or HCFA 1500 from your care provider attach it to this form- you do not need to fill section C in if the printed form is attached. As an excess policy, you must also include Explanation of Benefit (EOB) from your primary insurance