International Student Insurance Medical Benefits Plan

ACCIDENT AND SICKNESS QUESTIONNAIRE

Underwritten by: Great-West Life and Annuity Insurance Company

PLEASE FOLLOW THESE INSTRUCTIONS:

1. Read authorizations and complete questionnaire in full.
2. Limit information to one claimant.
3. Attach claim from doctor and/or prescription receipts.
4. Sign and Date.

MAIL COMPLETED FORM TO:

The Lewer Agency, Inc.
P.O. Box 32247
Kansas City, MO 64171-5247

For Customer Service inquiries, please call 1-800-821-7710 or e-mail to tlasip@lewer.com

Name of Student: ________________________________ Date of Birth: ____________________
Name as it appears on visa — Month /Day/ Year

Name of School: ______________________________ Student's Insurance I.D. Number : ________________

Present mailing address: ____

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Name of Patient: ________________________________ Date of Birth: ____________________
If different from student — Month/Day/Year

Relationship to student: ___________ Gender: ___________ Home Country: ____________________
Self/Husband/Wife/Child — Male/ Female

Date of injury or date symptoms of illness were first noticed: ______________________________

If claim is result of injury or accident, describe how it occurred (if auto accident, attach copy of police report and copy of your driver's license: ____

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If injury, was it due to participation in intercollegiate sports? ________ professional sports? _______ If yes, give name of sport: ____

If sickness, list symptoms: ____

Give the name and address of doctor who is treating you now for this illness or accident: __________________

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Have you had any prior treatment for this condition? _________ If yes, give name and address of the doctor who treated you last and the date treated (include services in your home country): ___________________________

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List any prescription medications that you are currently taking: ______________________________

Do you have any other insurance (school insurance, travel insurance, auto insurance, spouse's insurance)? __________

If yes, list the company's name, address, and policy number: ________________________________

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I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, employer, school, or third party administrator, having information as to diagnosis, treatment and/or prognosis of any of my physical or mental conditions (and any of my non-medical information necessary to the processing of claims), to give the blanket policyholder, THE LEWER AGENCY, INC., GREAT-WEST LIFE AND ANNUITY INSURANCE COMPANY, or their legal representatives, any and all such information. I specifically consent to the release of any of the above information which may be protected under the Family Educational and Privacy Rights Act including without limitations records of enrollment, attendance or payment of tuition related to my attendance at any Educational Institution to the blanket policyholder, THE LEWER AGENCY, INC., GREAT-WEST LIFE AND ANNUITY INSURANCE COMPANY, or their legal representatives.

I UNDERSTAND the information obtained with this Authorization will be used to determine my eligibility for coverage and/or benefits under a LewerMark insurance plan. Any such information will not be released by THE LEWER AGENCY, INC. or GREAT-WEST LIFE AND ANNUITY INSURANCE COMPANY, except to the blanket policyholder, third party administrator, reinsuring companies, or other persons or organizations performing services in connection with the plan, or as may be otherwise lawfully required.

I AGREE that: a copy of this Authorization shall be as valid as the original; this Authorization shall be valid for twelve months from the date shown below, or for the duration of this claim, if longer; and I am aware that I may request a copy of this Authorization.

I HEREBY AUTHORIZE payment of benefits, if any, directly to my Medical Providers for this claim.

X____ ____________________
PATIENT'S SIGNATURE — DATE

(If Patient is under eighteen (18) years of age or incapacitated, Parent or Guardian must sign. If Patient is deceased, Personal Representative or next of kin must sign.)

Any person who knowingly and with intent to defraud files a statement of claim containing any materially false information commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties.