

PROOF OF LOSS FORM

The furnishing of this form, or its receipt 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. Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

1 - COVERAGE INFORMATION - This information can be found on your Insurance I.D. Card

Insurance Company: <u>Liaison International</u>	Name of Group/Plan: <u>LON12-120101-01TM</u>	Policy/Certificate # <u>11VLN12-52085</u>
Coverage Effective Date: (Month/Day/Year) <u>09</u> <u>07</u> <u>2014</u>	Coverage Termination Date: (Month/Day/Year) <u>02</u> <u>26</u> <u>2015</u>	

2 - PRIMARY INSURED INFORMATION

3 - CLAIMANT/PATIENT INFORMATION

Name of Insured: <u>Rodney Larson</u>	Name of Claimant: <u>Rodney Larson</u>
Date Of Birth (Month/Day/Year): <u>09</u> <u>27</u> <u>1944</u>	Date Of Birth (Month/Day/Year): <u>09</u> <u>27</u> <u>1944</u>
Sex: ☒ M ☐ F	Sex: ☒ M ☐ F

4 - CURRENT ADDRESS

5 - PERMANENT ADDRESS

Current Residence Address: _____ <u>Royal Park Hotel</u> <u>Ning-gyo-cho, Tokyo Japan</u>	Permanent Address In Home Country: _____ <u>4713 Dominick Drive</u> <u>Minnetonka, MN 55343</u> <u>USA</u>
Daytime Phone # <u>(952) 960-1935</u> Email Address: <u>rodlarson100@yahoo.com</u> If Applicable, Date of Arrival in U.S. (Month/Day/Year): _____	If Applicable, Date scheduled to return to Home Country: (Month/Day/Year): <u>03</u> <u>07</u> <u>2015</u>

6 - MEDICAL INFORMATION

If Injured, provide details, such as how, when, and where injury occurred.

I had an episode around noon on Monday, January 20 where I experienced heart palpitations and numbness in my left arm and leg. This condition lasted for about a 1/2 hour then subsided. The rest of that day was quite normal. Then, again on Tuesday, January 21 I again experienced another episode similar to the one on Monday. However, this time the symptoms did not subside and lasted for about 2 hours. I then decided I had better seek medical attention and asked my co-workers to help me get to an emergency room. For the rest, see the attached Attending Physician's Statement.

NAME OF CLAIMANT/PATIENT <u>Rodney Lester Larson</u>	POLICY/CERTIFICATE # <u>11VLN12-52085</u>
7 - If Illness, advise when and where symptoms first occurred and nature of illness: see Section 6 above.	
8 - Name and Address of Consulting or Treating Physicians: Dr. Yamato Fukui, St. Luke's International Hospital, 9-1 Akashi-cho, Chuo-ku, Tokyo, Japan 104-8560	
9 - Have you ever been treated for this Illness before? ☒ Y ☐ N If Yes, When? <u>1999, 2006, 2014</u>	
10 - Provide Name and Address of your Primary Care Physician in your Home Country: Dr. Bella Shklyarova, Park Nicollet Clinic, 3900 Park Nicollet Blvd., St. Louis Park, MN 55416 Dr. Levi Tan, Maasin City, Southern Leyte, Philippines 6600	
11 - Indicate other Employer / Private/Government Medical Insurance coverage. (Include name, address, policy number and certificate number of Insurer): Medicare, Part B	
12 - Please advise names of any prescription medications you are presently taking or took during the past 6 months not related to your injury or illness: Furosemide, Lipitor	
13 - Please advise names of any prescription medications you have been prescribed for your injury or illness: Diovan, Atenolol, Plavix, Pletaal, Amlodopine	

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, relative or benefit plan administrator to furnish to Seven Corners, Inc. any and all information with respect to any injury or illness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, illness or loss is the basis of the claim and copies of all 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 identified above. I authorize the group policyholder, employer or benefit plan administrators to provide Seven Corners, Inc. with financial and employment related information and documents. I agree that I will provide Seven Corners, Inc. with any medical records, or other records, requested by Seven Corners, Inc. to process the claim. I understand that my failure to provide requested documents to Seven Corners, Inc. may result in denial of the claim. I understand that failure by any of the above referenced entities or individuals to provide information or documents to Seven Corners, Inc. may result in denial of the claim. In addition, I hereby certify that the above information is true and correct to the best of my knowledge and belief. I understand that any false statements made on this form or omissions of information requested by this form may result in denial of the claim. I acknowledge and understand the Fraud Notices on Page 3 of this document.

Rodney Lester Larson
 Signature of Patient/Claimant or Parent, If Claimant is a Minor

January 27, 2015
 Date

PAYMENT AUTHORIZATION FORM

1. For an ACH, if the bank is located in the United States, complete boxes 1 and 2. (The names in box 1 and 2 must match.)
2. For an ACH, if the bank is located outside of the United States, complete boxes 1 and 3. (The names in box 1 and 3 must match.)
3. For a wire transfer, complete boxes 1 and 3. (The names in box 1 and 3 must match.)
4. For a check, complete boxes 1 and 2. (The names in box 1 and 2 must match.)

METHOD OF PAYMENT - ONE MUST BE SELECTED

☒ ACH

Only in U.S. \$, Canada \$
Euros & Pounds

☐ Check

Check will be written and shipped to
person in "Contact Information" field.

☐ International Wire Transfer

1 - CONTACT INFORMATION

(P.O. Boxes are not accepted)

Name: Rodney Lester Larson

Physical/Street Address: 4713 Dominick Drive, Minnetonka, MN 55343

Email: rodlarson100@yahoo.com

Telephone Number: 1-952-960-1935

I authorize Seven Corners, Inc. to contact me using the email address I provided in this form to discuss and/or inform me of payment confirmation.

2 - US ACCOUNT INFORMATION - COMPLETE FOR ACH PAYMENT IF BANK IS IN THE U.S. (NO FEES APPLIED)

(Name in "Contact Information" must match name on bank account)

Account Type: ☒ Checking ☐ Savings

Account Holder(s) Name: Rodney L. Larson

Full Bank Name: First Minnetonka City Bank

Complete Bank Address: 14550 Excelsior Blvd., Minnetonka, MN 55345

ABA Routing Number: 091014458

Account Number: 299671

3 - INTERNATIONAL / NON-US ACCOUNT INFORMATION - COMPLETE FOR WIRE TRANSFER PAYMENT OR ACH OUTSIDE THE U.S.

Preferred Reimbursement Currency: _____

Full Bank Name: _____ Branch Name/Number: _____

Complete Bank Address: _____

Account Holder(s) Name: _____

(Exact, full, legal name(s) of account holder(s) as it appears on bank statements. Joint accounts require all names.)

Account Number: _____

Complete the fields below as appropriate for your specific account. Please contact your bank to confirm the exact information required to successfully receive a foreign funds transfer.

Routing Number: _____ SWIFT/BIC: _____

IBAN: _____ CLABE: _____

BSB: _____ Sort Code: _____

Other (please specify): _____

I hereby authorize Seven Corners, Inc. (hereinafter COMPANY) to mail any payments to the above listed address and to deposit any amounts owed me for reimbursement of medical expenses or services rendered by initiating credit entries to my account at the financial institution (hereby BANK) indicated above. Further, I authorize BANK to accept and to credit any credit entries indicated by COMPANY to my account. In the event that COMPANY erroneously deposits funds in my account (by way of example, I am not entitled to the funds or the amount of deposit is incorrect or such funds are deposited in the wrong account), I authorize COMPANY to debit or credit my account in the amount necessary to correct the initial deposit, but in no case shall any debit exceed the amount of the initial deposit. I further agree COMPANY is not responsible for any transaction fees charged and will release Seven Corners of any liability in the event of lost or stolen payments.

Rodney Lester Larson
Account Holder Signature

January 27, 2015
Date

St. Luke' s International Hospital

9-1 Akashi-cho, Chuo-ku, Tokyo Japan 104-8560

Phone: 03-3541-5151 Fax: 03-3544-0649

診 断 書

ATTENDING PHYSICIANS STATEMENT

患者名 Patient name LARSON RODNEY	患者生年月日 Date of birth September 27, 1944
症状が現れた日 Date when illness or injury was noticed January 17, 2015	妊娠による疾病ですか。 Is the condition due to pregnancy? ☐ YES ☒ NO
初診日 Date of first consultation January 21, 2015	他の疾病の影響はございますか。 Is there any other disease related to the present condition? Hypertension, Dyslipidemia
患者は以前に同様の症状を訴えたことがありますか。 Has the patient ever had the same or similar symptoms? ☒ YES ☐ NO	いつ頃でしょうか。 If yes, give approximate date. In 1999 以前の症状で実際に治療を受けましたか。 Yes, PCI (percutaneous catheter intervention) was performed three times in 1999, 2006, 2014.
治療の期間 Period of treatment ☐ Outpatient visit ☐ Home visit ☒ Hospitalization	外来 From 往診 入院 Date : January 21, 2015 Date : January 22, 2015
傷病名 Diagnosis Unstable Angina Pectoris	
経過 State of illness Mr. LARSON was transferred to our hospital because of two hours lasting chest discomfort feeling on January 21, 2015. The symptom disappeared at our hospital. There was no ST change on ECG and no abnormalities on Lab data. But, percutaneous catheter intervention (PCI) with stent had been performed three times before. Therefore, we estimated that the fatality rate was 30% without cardio angiography (CAG) and PCI. So, we recommended admission and CAG to him. He was admitted with suspicion of unstable angina pectoris and cardio angiography (CAG) was performed immediately. CAG showed another occlusion of coronary artery (75-90% occluded mid LCx). Then, Stenting (Xience Expedition 2.5x18mm) was performed and finished successfully. There was no adverse event during one day observe after the procedure. He was discharged on January 22, 2015.	
他の機関で治療を受けた場合 その病院名 Name of facility if services were provided for this illness or injury. No.	
治癒日 Date of recovery He needs Follow up at his regular doctor.	
治療内容に関しては、添付されているレシートをご参照ください。 Medical services	Refer attached receipt(s).
日付 Date 住所 Address	January 22, 2015 St. Luke' s International Hospital 9-1 Akashi-cho, Chuo-ku, Tokyo Japan 104-8560
署名 YAMATO FUKUI Yamato Fukui	

*Of the United States,
in Order to form a more perfect Union,
establish Justice, insure domestic Tranquility,
provide for the common defence,
promote the general Welfare, and secure
the Blessings of Liberty to ourselves and
our Posterity, do ordain and establish this
Constitution for the United States of America.*

Rodney Lester Larson

SIGNATURE OF BEARER / SIGNATURE DU TITULAIRE / FIRMA DEL TITULAR

22

PASSPORT
PASSEPORT
PASAPORTE

UNITED STATES OF AMERICA

Type / Type / Tipo Code / Code / Código Passport No. / No. du Passeport / No. de Pasaporte

P USA

Surname / Nom / Apellidos

LARSON

Given Names / Prénoms / Nombres

RODNEY LESTER

Nationality / Nationalité / Nacionalidad

UNITED STATES OF AMERICA

Date of birth / Date de naissance / Fecha de nacimiento

27 Sep 1944

Place of birth / Lieu de naissance / Lugar de nacimiento

IOWA, U.S.A.

Date of issue / Date de délivrance / Fecha de expedición

01 Nov 2010

Date of expiration / Date d'expiration / Fecha de caducidad

31 Oct 2020

Endorsements / Mentions Spéciales / Anotaciones

SEE PAGE 51

Sex / Sexe / Sexo

M

Authority / Autorité / Autoridad

United States

Department of State



P<USALARSON<<RODNEY<LESTER<<<<<<<<<<<<<<<<<<<

4521050580USA4409276M2010315180719192<193694

Every generation has the obligation to free men's minds
for a look at new worlds . . . to look out from a higher
plateau than the last generation.

Ellison S. Onizuka

This document contains sensitive
electronics. For best performance,
do not bend, perforate or expose
to extreme temperatures.

A. RESTRICTIONS ON IMPORTATION OF GOODS AND SERVICES For information, write the Department of the Treasury, Office of Foreign Assets Control, Treasury Annex, 1500 Pennsylvania Avenue N.W., Washington, D.C. 20220, or consult <http://www.treas.gov/ofac>

B. CUSTOMS & BORDER PROTECTION Contact Customs & Border Protection (CBP), for a copy of "Know Before You Go" and "Pets, Wildlife - Licensing and Health Requirements," at <http://www.cbp.gov/xp/cgov/travel/>

C. AGRICULTURE For a copy of "Travelers' Tips On Bringing Food, Plant, and Animal Products into the United States," contact the U.S. Department of Agriculture, <http://www.aphis.usda.gov/travel/> See also U.S. Fish and Wildlife Service, <http://www.fws.gov/TipsforTravelers.htm> for other important "Information for International Travelers."

D. U.S. TAXES All U.S. citizens working and residing abroad are required to file and report on their worldwide income. Consult IRS Publication 54, "Tax Guide for U.S. Citizens and Resident Aliens Abroad," available at <http://irs.gov/publications/p54/index.html>

E. SOCIAL SECURITY Write to the Social Security Administration, Office of International Operations, P.O. Box 17769, Baltimore, MD 21235, or consult <http://www.ssa.gov/international/> about receiving payments while outside the U.S., or contact the nearest Social Security office in the United States or at a U.S. embassy or consulate abroad.

EXACT WEBSITE ADDRESSES SUBJECT TO CHANGE.

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4 5 2 1 0 5 0 5 8

Democracy is based upon the conviction that there

are extraordinary possibilities in ordinary people.

Harry Emerson Fosdick

Visas



JAPAN IMMIGRATION INSPECTOR
上陸許可
LANDING PERMISSION
許可年月日 19 JAN. 2015
Date of permit:
在留期限 19 APR. 2015
Until:
在留資格 短期滞在
Status: Temporary Visitor
在留期間
Duration: 90days
NARITA(2)

1410709958

RT 3176902



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9

診療費請求書 BILL



St. Luke's
International
Hospital

聖路加国際病院

St. Luke's International Hospital

〒104-8560 東京都中央区明石町9-1
9-1 AKASHI-CHO CHUO-KU TOKYO, JAPAN
TEL 03-3541-5151(代)

患者番号 ID	1237930-1
氏名 NAME	ラーソン ロード LARSON RODNEY 様

入 外 区 分 Outpatient/Inpatient	診 療 科 Department	病 室 Patient Room No.	適 用 保 険 Type of Insurance	負担割合 Patient Co-pay Ratio
外 来 Outpatient 入 院 Inpatient	循 環 器 CARDIO	IMC02	自 25	100 %

発行番号 13480436
発行年月日 2015/ 1/22
Date of Issue y / m / d

診 療 年 月 日 Date of Consultation	入 院 年 月 日 Date of Admission	期 間 Period	実日数 Number of Days
**** 年 ** 月 ** 日	2015 年 1 月 21 日	2015 年 1 月 21 日 ~ 2015 年 1 月 22 日	2 日

保険分合計 Patient Co-pay	自費分合計 Ins. non-covered	調整額 Adjustment	消費税 Tax
	2685740		214859

請 求 金 額 (税込) Total Amount Billed (Incl. Tax)
2,900,599 円 Yen

総保険点数 Total Insurance Unit
点

ご請求日 Date
2015. 1. 22 1397

《内訳 / Itemization》

合計 ￥906,449.-

区 分 ITEM	初・再診 Consultation	入院等 Admission	医学管理等 Special Med.Care	在宅医療 Home Care	投薬/処方 Medicine/Prescription	注 射 Injection	処 置 Treatment	手 術 Operation
保険 Ins.	点数 金額¥							
自費 Ins. non-covered ¥	7050	285770	26870		1630	9550		2315290
区 分 ITEM	検 査 Tests	画像診断 X-ray	リハビリテーション Rehabilitation	精神科専門療法 Psychotherapy	麻 酔 Anesthesia	放射線治療 Radiation Therapy	歯冠修復 及び欠損補綴 Dental	病 理 診 断 Pathology
保険 Ins.	点数 金額¥							
自費 Ins. non-covered ¥	32540	5250						
区 分 ITEM	保険外併用療養費 Non-insured	健 診 Check-Up	室料差額 Room Charge	追加食 Additional Meal	通 信 Communication Charge	洗 濯 Laundry	文 書 Documentation	そ の 他 Miscellaneous

診療費請求書 BILL



St. Luke's
International
Hospital

聖路加国際病院

St. Luke's International Hospital

〒104-8560 東京都中央区明石町9-1
9-1 AKASHI-CHO CHUO-KU TOKYO, JAPAN
TEL 03-3541-5151(代)

患者番号 ID	1237930-1
氏名 NAME	ラーソン ロード LARSON RODNEY 様

入外区分 Outpatient/Inpatient	診療科 Department	病室 Patient Room No.	適用保険 Type of Insurance	負担割合 Patient Co-pay Ratio
外※来Outpatient 入院 Inpatient	循環器 CARDIO	IMC02	自25	100 %

発行番号 13480685
発行年月日 2015/ 1/22
Date of Issue y / m / d

診療年月日 Date of Consultation	入院年月日 Date of Admission	期間 Period	実日数 Number of Days
****年 **月 **日	2015年 1月 21日	2015年 1月 21日 ~ 2015年 1月 22日	2日

保険分合計 Patient Co-pay	自費分合計 Ins. non-covered	調整額 Adjustment	消費税 Tax
	5417		433

請求金額(税込) Total Amount Billed (Incl. Tax)
5,850 円 Yen

総保険点数 Total Insurance Unit
点

ご請求日 Date
2015. 1. 22 1098

《内訳 / Itemization》

区分 ITEM	初・再診 Consultation	入院等 Admission	医学管理等 Special Med.Care	在宅医療 Home Care	投薬／処方 Medicine/Prescription	注 射 Injection	処 置 Treatment	手 術 Operation
保険 Ins.	点数 金額¥							
自費 Ins. non-covered ¥								
区分 ITEM	検 査 Tests	画像診断 X-ray	リハビリテーション Rehabilitation	精神科専門療法 Psychotherapy	麻 酔 Anesthesia	放射線治療 Radiation Therapy	歯冠修復 及び欠損補綴 Dental	病理診断 Pathology
保険 Ins.	点数 金額¥							
自費 Ins. non-covered ¥								
区分 ITEM	保険外併用療養費 Non-insured	健 診 Check-Up	室料差額 Room Charge	追加食 Additional Meal	通 信 Communication Charge	洗 濯 Laundry	文 書 Documentation	そ の 他 Miscellaneous

January 27, 2015

To Whom It May Concern:

The two (2) bills from St. Luke's International Hospital are in Japanese yen. The first bill is for a total of **2,900,599 Yen** for the Doctor fees and Hospital fees and the second bill is for **5,850 Yen** for Pathology.

The total is then **2,906,449 Yen**. **2,000,000 Yen** was paid by a friend and the remaining **906,449 Yen** was paid by MTS-Systems-Japan.

The approximate exchange rate on January 21, 2015 was **115.83** Yen/US Dollar. The total bill is then approximately **\$ 25,092.37** in US Dollars.

Thank You For Your Purchase!



Your Purchase Is Complete!

Please keep your Virtual ID Card™ with you at all times during your travels
Be sure to view the following: [Virtual ID Card™](#) | [Official Program Summary](#)



Receipt of Purchase

Purchase Date: 01/12/2015
Credit Card: XXXXXXXXXXXXX7481
Amount: \$316.78
Address:
Rodney Larson
4713 Dominick Drive
Minnetonka, MN 55343
United States of America

rodlarson100@yahoo.com

Included with your purchase are a wallet ID card and your complete Virtual ID Card. We recommend that you keep both with you at all times during your travels. Should you have any questions about your membership or the services provided, please feel free to call us at 800-335-0611, Monday through Friday between 8am to 5pm EST or, email us at info@sevencorners.com.

Thank you for allowing us to be of service to you!
GoHealthPlan Insurance Solutions & Seven Corners, Inc.

Wallet ID Card



Seven Corners, Inc.
Travel Insurance Benefits

Liaison International
Primary Insured: Rodney Larson
Certificate #: 11VLN12-52085
Group Number: LON12-120101-01TM
Eff. Date: 09/07/2014 | **Exp. Date:** 02/26/2015



The person named on the front of this card is eligible for certain Services and Benefits as outlined in the material provided.

For EMERGENCY evacuation and medical assistance, or travel assistance ONLY, call Seven Corners Assist 24/7/365:

U.S., Canada & Caribbean: 1-800-690-6295 (Toll Free)
International: Toll Free Country Access Codes + 800-690-6295
Collect Calls: 0-317-818-2808

For claims and benefits questions (Open M-F 8am-5pm EST):

U.S., Canada & Caribbean: 1-800-335-0477 (Toll Free)
International: Toll Free Country Access Codes + 800-335-0477
Collect Calls: 0-317-575-2656
Email: info@sevencorners.com



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WellAbroad.com
User Name : RoLarson11
Password : 52085

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<http://Community.SevenCorners.com>



summary of benefits

Liaison International			
Certificate Number	11VLN12-52085	Group Number	LON12-120101-01TM
Effective Date	09/07/2014	Expiration Date	02/26/2015
Coverage Days	173	Hazardous Sport Coverage	Declined
Medical Maximum	\$100,000	Deductible	\$250
AD&D Beneficiary	Jovelisa Larson	Beneficiary Relationship	SPOUSE
View Coverage Letter	Click Here		
Insured Information			
Name	Rodney Larson	Date of Birth	09/27/1944
Purchase Information			
Purchase Date	01/12/2015	Address	Rodney Larson 4713 Dominick Drive Minnetonka, MN 55343 United States of America
Credit Card	XXXXXXXXXXXX7481		
Amount	\$316.78		rodларson100@yahoo.com
Highlight Coverage Details			
Emergency Medical Evacuations:	US\$300,000	Return of Mortal Remains:	US\$50,000
Emergency Reunion:	US\$50,000	Loss of Checked Luggage:	US\$250
AD&D:	US\$25,000 Principal Sum for Insured or Insured Spouse, US\$5,000 for Dependent Child.	Coinurance:	After the deductible, program pays 100% to the chosen maximum
Questions About Your Coverage & Benefits		For Immediate Assistance	
U.S., Canada & Caribbean:	1-800-335-0477 (Toll Free)	Seven Corners Must Be Contacted:	
International: *	Toll Free Country Access Codes + 800-335-0477	• As soon as non-emergency hospitalization is recommended • Within 48 hrs of the first working day following an emergency admission • When your physician recommends any surgery including outpatient • For emergency evacuation, repatriation, and assistance services	
Collect Calls:	0-317-575-2656 (This line is only open during business hours, 8:00-5:00 pm EST)	U.S., Canada & Caribbean: 1-800-690-6295 (Toll Free) International: * Toll Free Country Access Codes + 800-690-6295 Collect Calls: 0-317-818-2808 (This line is monitored 24 hours a day)	
* Seven Corners utilizes AT&T for its toll free 800 numbers at www.usa.att.com/traveler/access_numbers/index.jsp. Virtually anywhere in the world you can dial an access code, then dial one of Seven Corner's 800 numbers and be connected to Seven Corners, Inc.			
Agent Information			
GoHealthPlan Insurance Solutions 1901 Avenue Of The Stars Suite # 615 Los Angeles, CA 90067 United States of America	Phone: 310-553-8383 Toll Free: 800-344-6870 Fax: 310-421-0404	Email: motticohen@msn.com Web: www.gohealthplan.com To Renew: https://renewal.sevencorners.com/	
Please Contact Your Agent for Further Information & Purchases			
Claim Submission		Preferred Provider Network	
Claims Must Be Faxed or Mailed To: Seven Corners, Inc. 303 Congressional Boulevard Carmel, IN 46032 Fax: 317-575-2256		To obtain a list of U.S. providers, contact Seven Corners Assist or visit www.sevencorners.com/ppo	