

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