USI Travel Insurance Select® - MEDICALEXPENSE CLAIM FORM

PARTICIPANT'S INFORMATION:

Account Name and Policy Number: _____

Name of participant (i.e. student): _____

Address:_____ City:_____ State:____ Zip Code:_____

Email Address: _____ Home Phone #:_____

Work Phone: _____ Cell #: _____

Address:_____ City:_____ State:_____ Zip Code:_____

LEGAL GUARDIAN INFORMATION:

Full Name: _____

Mailing Address: _____

Relationship to Participant: _____

Home Phone: (_____) _____/_____ Cell #: (_____) _____

Email Address: _____

Signature of participant's legal guardian: _____
(*** Please note: your signature indicates you are the legal guardian of the participant and authorizes payment issuance to you***)

TRAVEL SUPPLIER / PROVIDER INFORMATION:

Name of Tour Operator/Cruise Line/Airline you were traveling with:_____

Scheduled Date of Departure:_____/_____/_____ Scheduled Date of Return: _____/_____/_____

Origination: _____ Destination: _____

Flight Number: _____ Flight Number: _____

Air Carrier: _____ Air Carrier: _____

OTHER INSURANCE / AUTHORIZATION:

Do you have any other type of insurance?_____

If so, please provide the Company Name and Address:_____

Type of Policy:_____ Policy #:_____ Contact:_____Phone:_____

DETAILS OF SICKNESS / INJURY

Date Sickness or Injury began:_____ Date of first treatment:_____
Nature of sickness / details of accident:_____

_____

Have you ever been treated for this condition previously? Yes No . Date(s) of treatment(s):_____

Name, address and phone number of treating physician(s):

(1) Physician's Name:_____ Phone:_____
Address:_____

(2) Physician's Name:_____ Phone:_____
Address:_____

NEW YORK FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

AUTHORIZATION: I hereby authorize Crum & Forster, United States Fire Insurance Company or its representative, to inspect or secure copies of case history records or any other data necessary to determine eligibility of benefits. I also authorize Crum & Forster, United States Fire Insurance Company or its representative to release and share claim information including that which may be used in the identification and prevention of potential fraudulent activity to any insurance organization, fraud information clearinghouses, designated service providers and business associates assisting in the processing of this claim. A photostatic copy or facsimile of this authorization shall be deemed as effective and valid as the original. This authorization is valid for twelve (12) months from date of signature. **I HAVE REVIEWED AND ACKNOWLEDGE THE ATTACHED FRAUD WARNING.**

SIGNATURE OF INSURED_____ **DATE**_____

CLAIM DOCUMENTATION REQUIREMENTS:

Depending upon the circumstance involved in the loss, one or more of the following items may be required to complete the processing of your claim. Please place a check by those items you have attached. We recommend you keep copies of any items submitted with this claim.

Copies of itemized bills and/or statement from medical providers for services rendered in connection with your claim. These bills and/or statements must include the date of service, the service rendered, the charge for each service, and the diagnosis

If you have other insurance, we need the final disposition from the primary insurer listing payment or denial of your claim with them (Explanation of Benefit or "EOB").

Copies of the front and back of your cancelled checks and/or your credit card statements showing your payments for the trip; and a copy of your trip invoice.

Airline Ticket Stub/Receipt (if applicable)

Copies of your credit card statements and/or cancelled checks showing your payment for the medical service submitted

If medical expenses were incurred abroad, attach copies of your passport pages which identify you as the traveler and document your entrance into and exit from the country or countries where medical services were received

Other (please describe):_____

Please advise if you wish to be contacted via e-mail or regular mail_____

PLEASE COMPLETE THIS FORM IN FULL AND RETURN TO:

Attention: Co-ordinated Benefit Plans, LLC
On Behalf of United States Fire Insurance Company
P.O. Box 26222
Tampa, FL 33623

Email to: TravelTeam@cbpinsure.com or FAX: 800-560-6340
Toll Free: 877-539-6442
Direct Dial: 727-450-8795

IMPORTANT NOTICE

Fraud Warning: Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

Notice to Arizona Claimants: For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Notice to California Claimants: For your protection California law requires the following to appear on this form. Any person who knowingly presents 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.

Notice to Colorado Claimants: It is unlawful to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to District of Columbia Claimants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Notice to Hawaii Claimants: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

Notice to Idaho Claimants: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing a false, incomplete, or misleading information is guilty of a felony.

Notice to Kentucky Claimants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

Notice to Oklahoma Claimants: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

Notice to Pennsylvania Claimants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

Notice to Texas Claimants: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.