

MEDICAL EXPENSES CLAIM FORM

IMPORTANT: PLEASE READ THIS FORM CAREFULLY. IF THIS FORM IS NOT FULLY COMPLETED AND APPROPRIATE DOCUMENTATION PROVIDED, IT MAY DELAY THE HANDLING OF YOUR CLAIM.

SECTION 1 - INSURED INFORMATION

NAME OF INSURED	SOCIAL SECURITY NUMBER	DATE OF BIRTH	
STREET ADDRESS	CITY	STATE	ZIP CODE
GIVE NAME OF CO-INSURED/TRAVELING COMPANION	SOCIAL SECURITY NUMBER	DATE OF BIRTH	CERTIFICATE NUMBER OR PLAN CODE

SECTION 2 - TRAVEL INFORMATION

AGENCY	ADDRESS	TELEPHONE ()	FAX ()
TRAVEL AGENT'S NAME	E-MAIL	BOOKING/RESERVATION NUMBER	TRIP COST
DESTINATIONS	DEPARTURE DATE	RETURN DATE	

SECTION 3 - DETAILS OF SICKNESS OR INJURY

NATURE OF SICKNESS OR INJURY	DATE FIRST TREATED
DATE SICKNESS FIRST BEGAN. IF INJURY, PLEASE LIST DATE AND TIME OF INCIDENT	
IF INJURY, HOW AND WHERE DID ACCIDENT OCCUR?	
WAS ACCIDENT REPORT COMPLETED FOR THIS INCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE PROVIDE COPY	
WERE YOU TREATED FOR THIS CONDITION PRIOR TO THE PURCHASE OF THIS INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE LIST ALL DATES:	
IF "YES" TO ABOVE, PLEASE PROVIDE NAME, ADDRESS AND PHONE NUMBER OF TREATING PHYSICIAN:	

SECTION 4 - MEDICAL FACILITIES

LIST HOSPITAL WHERE TREATED AND DOCTORS CONSULTED FOR THIS CONDITION

NAME	ADDRESS	TELEPHONE	FAX	DATES

SECTION 5 - OTHER INSURANCE INFORMATION

NOTE: YOUR TRAVEL INSURANCE POLICY IS EXCESS OVER ANY OTHER HEALTH/MEDICAL INSURANCE YOU MAY HAVE. IF YOU HAVE NOT ALREADY DONE SO, YOU WILL NEED TO FILE A CLAIM WITH YOUR PRIMARY AND ANY SUPPLEMENTAL CARRIERS FIRST.

DO YOU HAVE OTHER HEALTH/MEDICAL INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAVE YOU SUBMITTED A CLAIM TO YOUR PRIMARY/SUPPLEMENTAL INSURANCE CARRIER? <input type="checkbox"/> YES <input type="checkbox"/> NO
PRIMARY INSURANCE CARRIER	POLICY NUMBER
	PHONE NUMBER ()
SUPPLEMENTAL INSURANCE CARRIER	POLICY NUMBER
	PHONE NUMBER ()

SECTION 6 - DESCRIPTION OF MEDICAL EXPENSES AND AMOUNT CLAIMED

PLEASE LIST ALL MEDICAL EXPENSES INCURRED AS A RESULT OF THIS SICKNESS/INJURY. ENCLOSE COPIES OF MEDICAL BILLS, REPORTS AND EXPLANATION OF BENEFITS FROM YOUR PRIMARY AND SUPPLEMENTAL INSURANCE.

NAME OF PROVIDER	DATE INCURRED	AMOUNT OF BILL	AMOUNT PAID BY OTHER INSURANCE	AMOUNT CLAIMED	(CSA USE ONLY)

***IMPORTANT: DOCUMENTATION SUBSTANTIATING AMOUNTS CLAIMED MUST BE PROVIDED** **TOTAL AMOUNT CLAIMED:**

COMPLETE OTHER SIDE

CSA TRAVEL PROTECTION • P.O. BOX 939057 • SAN DIEGO, CA 92193-9067 • (800) 541-3522

SECTION 7 - PHYSICIAN'S STATEMENT (IF POSSIBLE, PLEASE HAVE COMPLETED BY ATTENDING PHYSICIAN)

FULL NAME OF PATIENT		DATE OF BIRTH	
THIS TREATMENT IS THE RESULT OF <input type="checkbox"/> SICKNESS <input type="checkbox"/> INJURY		DIAGNOSIS	
		ICD CODE	
ON WHAT DATE DID SYMPTOMS FIRST APPEAR?		ON WHAT DATE DID THE PATIENT FIRST CONSULT WITH YOU ABOUT THIS CONDITION?	
PLEASE LIST ALL DATES OF EXAMINATION/TREATMENT FOR THIS CONDITION FROM INITIAL CONSULT TO PRESENT			
WAS PATIENT REFERRED BY ANOTHER PHYSICIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE PHYSICIAN'S NAME:			
PHYSICIAN'S NAME AND ADDRESS			TELEPHONE ()
IS THIS CONDITION A COMPLICATION OF AN UNDERLYING CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE SPECIFY			
IF ACCIDENT, WHEN AND WHERE DID ACCIDENT OCCUR?		HOW DID ACCIDENT OCCUR?	
PHYSICIAN'S SIGNATURE AND DEGREE		TAX ID/IRS NUMBER	FAX NUMBER ()
STREET ADDRESS		CITY/STATE	ZIP CODE
			TELEPHONE ()

SECTION 8 - COMMENTS

USE THIS SPACE FOR ANY ADDITIONAL/CLARIFYING INFORMATION THAT MAY HELP US PROCESS YOUR CLAIM

PLEASE NOTE: YOUR POLICY MAY NOT PROVIDE COVERAGE FOR CERTAIN "PRE-EXISTING" MEDICAL CONDITIONS. PLEASE READ YOUR POLICY CAREFULLY.**WARNING AND NOTICE:**

Any person who knowingly and with intent to defraud, injure or deceive an insurance company or other person files a statement of claim or application containing any materially false or misleading information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of a crime and may be subject to civil penalties, fines, and/or imprisonment.

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.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado Division of Insurance with the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Pennsylvania: 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.

BY SUBMITTING THIS CLAIM, I CERTIFY THAT ALL ANSWERS TO THESE QUESTIONS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

INSURED'S SIGNATURE	DATE	RESIDENCE TELEPHONE ()	BUSINESS TELEPHONE ()
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