# Medical Expense Claim Form

While on my trip, I had expenses for medically necessary treatment due to an injury or sickness.

## Step 1 – Provide Documentation (provide all)

**Provide the following required documentation:**

- ☐ Provide copies or photos of your itinerary and paid invoice.
- ☐ Provide copies or photos of itemized bills or similar documentation from your healthcare providers.
- ☐ Provide copies or photos of medical reports and/or physician statements to support your claim; include documentation showing diagnosis and treatment.
- ☐ Provide copies or photos of the payment and/or explanation of benefits from your primary or supplemental insurance carrier, if applicable.
- ☐ Provide copies or photos of any documentation that supports the reason for your claim.

## Step 2 – Submit All Pages of this Claim Form

**Completed claim form and documentation can be submitted by either:**

- ☐ **Scan**
- ☐ **Email to:** support@zurichtravelclaims.com
- ☐ **Mail to:**
  Zurich Travel Claims
  P.O. Box 1019, Youngwood, PA 15697-0919
- ☐ **Fax to:** 866-551-1704

**If you have questions about your claim, our customer service team is available by**
phone at 833-804-4848, Monday - Friday 8:30am – 8:00pm ET or by email at support@zurichtravelclaims.com.

## About Me

| | | |
|---|---|---|
| **Claimant's Name** (First and Last) | | **Confirmation/Policy Number** |
| **Gender** | **Date of Birth** *(mm/dd/yyyy)* | **Last 5 Digits of Social Security Number** |
| **Mailing Address** ☐ *Check if this is a change of address.* | **City** | **State** **Zip Code** |
| **Primary Phone Number** | **Secondary Phone Number** | **Email Address** |
| **How would you like your claim paid?** | ☐Check | ☐Electronic fund transfer<br>*From Zurich via Dream Payments<br>*Instructions for steps to receive payment via this option will be emailed upon claim approval |
| **Name of agency/company you purchased your travel insurance from** | | **Date initial deposit paid for trip** *(mm/dd/yyyy)* |

## About What Happened

**Please provide the circumstances of the sickness or injury**

| | | | |
|---|---|---|---|
| **Date of onset of sickness or injury** *(mm/dd/yyyy)* | **ICD Code** | **Location** *(City, Country)* | |
| **Date of first consultation** *(mm/dd/yyyy)* | **Name of Physician who treated you** | **Were you Represented by an Attorney?** ☐ Yes ☐ No | |
| **Were you hospitalized?** ☐ Yes ☐ No | **If yes, name of hospital** | **Admission Date** *(mm/dd/yyyy)* | **Discharge Date** *(mm/dd/yyyy)* |
| **Did you contact the Assistance Provider?** ☐ Yes ☐ No | **If yes, date contact was made** *(mm/dd/yyyy)* | **Have you ever had the same or similar condition?** ☐ Yes ☐ No | **If yes, when did the condition occur?** *(mm/dd/yyyy)* |

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**Note** – Benefits under any coverage will not be paid for expenses reimbursed or services provided by any other source. Benefits cannot be duplicated under this protection plan and claims will be adjusted in accordance with the terms of the policy.

| Were you taking prescribed medication for this condition prior to your trip? ☐ Yes ☐ No | Were the prescriptions/dosages changed prior to trip departure? ☐ Yes ☐ No | If yes, please indicate the date *(mm/dd/yyyy)* | Name of Medication |
|---|---|---|---|
| Name and full address of Family Physician | | | Telephone Number |

## About the Medical Expenses Incurred

| Name of Medical Service Provider (i.e. hospital, clinic) / Doctor | Date of Service *(mm/dd/yyyy)* | Prescribed Medication *(Yes / No)* | Amount on Invoice *(USD)* | Did You Pay this Invoice? *(Yes / No)* | Amount Paid by Other Insurance *(USD)* | Amount Requested for Reimbursement *(USD)* |
|---|---|---|---|---|---|---|
| | | ☐ Yes ☐ No | | ☐ Yes ☐ No | | |
| | | ☐ Yes ☐ No | | ☐ Yes ☐ No | | |
| | | ☐ Yes ☐ No | | ☐ Yes ☐ No | | |
| | | ☐ Yes ☐ No | | ☐ Yes ☐ No | | |
| | | ☐ Yes ☐ No | | ☐ Yes ☐ No | | |
| **Total Amount Requested for Reimbursement in USD** | | | | | | |

**If you have more expenses, please provide a breakdown on an additional sheet using format provided above.**

## About Other Coverage

**Do you have any other insurance coverage? (e.g. Medicare, Blue Cross, workplace/group insurance, credit cards, etc.)** ☐Yes ☐No **If YES, complete the following:**

**1. Name of Insurance Company** **Policy Number** **Phone Number**

**Address of Insurance Company**

**2. Name of Insurance Company** **Policy Number** **Phone Number**

**Address of Insurance Company**

**Was your medical emergency caused by an accident?** ☐Yes ☐No **If YES, do you believe a third party was responsible?** ☐Yes ☐No **If YES, complete the following:**

**Name of Third Party** **Phone Number**

**Third Party Mailing Address** **City** **State** **Zip Code**

**If the claim has been submitted to another insurance company for these expenses, please provide:**

**Name of Insurance Company** **Claim Number**

**Please attach a copy of their Explanation of Benefits.**

**I DECLARE THE ABOVE INFORMATION IS TRUE, COMPLETE AND CORRECT.**

I understand that my claim information may be reported as per Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). I authorize any other insurance company, under which I have coverage to disclose information as may be necessary with respect of my claim with Zurich American Insurance Company directly. I also authorize Zurich American Insurance Company to disclose to any other insurance company, under which I have coverage, any and all information as may be necessary with respect to my claim.

**Signature of Claimant** **Date** *(mm/dd/yyyy)*

☐ I acknowledge that **checking this agreement box** and **typing my name** in the signature box above constitutes an electronic signature and consent to file this claim electronically. Electronic signatures are legal and enforceable in the same fashion as a traditional signature.

# Medical Expense Claim Form

**Note** – Benefits under any coverage will not be paid for expenses reimbursed or services provided by any other source. Benefits cannot be duplicated under this protection plan and claims will be adjusted in accordance with the terms of the policy.

## Patient Consent Form

**Patient's full name at time of treatment** (First and Last) **Date of Birth** *(mm/dd/yyyy)*

**Full Address**

**Purpose of release:** **Effective Date of Insurance Coverage:**

***ADJUDICATION OF TRAVEL INSURANCE CLAIM***

**List all physicians consulted for this condition and hospital where confined:**

| **Name** *(first and Last)* | **Address** | **Phone Number** | **Fax Number** | **Dates** *(mm/dd/yyyy – mm/dd/yyyy)* |
|---|---|---|---|---|
| | | | | - |
| | | | | - |
| | | | | - |

You are authorized to give Zurich American Insurance Company and its affiliates, reinsurers, agents, consumer reporting agency, or independent claims administrator acting on behalf of Zurich American Insurance Company, any information concerning insurance coverage, medical care, advice, treatment or supplies, or any other information that may have bearing on the request for benefits submitted in conjunction with the travel-insurance policy.

**Information to be released:**
All medical records of the Patient for up to 180 days before the Effective Date of Insurance Coverage as shown above through the date of this consent as shown below as applicable based on the patients age as outlined the policy. "Medical records" includes, without limitation, diagnosis list, medication list, physician dictation, office notes, physical therapy records, occupational therapy records, pathology reports, cytology reports and the results of all laboratory tests.

**Send to:**
Zurich Travel Claims
P.O. Box 1019
Youngwood, PA 15697-0919
Telephone: 833-804-4848 Fax: 866-551-1704

**By signing below, I understand that:**

1. The information in my health record may include information relating to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I have the right to revoke this consent at any time by providing my written revocation to the facility where my records are kept.
3. A revocation will not apply to information that has already been released in response to this consent.
4. A revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. Unless otherwise revoked, this consent will expire in six months.
6. Consenting to the disclosure of this health information is voluntary. I can refuse to sign this consent.
7. Any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I authorize Zurich Travel Claims to disclose my health or claim information to any relevant source (e.g., airline, tour operator, travel suppliers, etc.) for the purpose of obtaining recoveries or outstanding refunds after my insurance claim has been settled. I hereby assign to Zurich American Insurance Company any benefits or recoveries obtained from these sources for losses covered under this policy. I direct these sources to forward reimbursement to Zurich Travel Claims with regard to these losses.

**Signature of Patient or Authorized Person** **Date** *(mm/dd/yyyy)*

**Relationship and reason patient is unable to sign**

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**Note** – Benefits under any coverage will not be paid for expenses reimbursed or services provided by any other source. Benefits cannot be duplicated under this protection plan and claims will be adjusted in accordance with the terms of the policy.

**All states other than those listed:**
Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit with the intent to defraud or deceive any insurer is guilty of a crime and may be subject to criminal and civil penalties and denial of insurance benefits.

**AL, AR, AZ, CO, DE, DC, FL, IA, ID, IN, KY, LA, MD, ME, MN, NM, OK, RI, TN, TX, VA, WA, WV.**
FOR YOUR PROTECTION STATE LAW REQUIRES THE FOLLOWING STATEMENT TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF LOSS OR BENEFIT WITH THE INTENT TO DEFRAUD OR DECEIVE ANY INSURER IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CRIMINAL AND CIVIL PENALTIES AND DENIAL OF INSURANCE BENEFITS.

**Alaska**
A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**California**
For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**New Hampshire**
Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

**New York**
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.

**New York for Auto**
Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, 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 value of the subject motor vehicle or stated claim for each violation.

**Ohio**
Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**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 a person to criminal and civil penalties.

**Puerto Rico**
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) dollars and not more than ten thousand ($10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**I ACKNOWLEDGE** that I have read the fraud statement that applies to my state of residence. If my state of residence is not listed, I acknowledge that I have read the "All states other than those listed".

**Signature of Claimant** **Date** *(mm/dd/yyyy)*

☐ I acknowledge that **checking this agreement box** and **typing my name** in the signature box above constitutes an electronic signature and consent to file this claim electronically. Electronic signatures are legal and enforceable in the same fashion as a traditional signature.