# Accident & Sickness

## Claim Form & Claimant's Statement

Note: Travel insurance products sold by UnitedHealthcare Global are underwritten by Catlin Insurance Company, Inc., a member of the XL Catlin group of companies.

Please complete this form to make a travel insurance claim.

**PARTICIPANT'S INFORMATION:**

Plan Number and/or School Name:_____

Name: _____ Date of Birth:___/____/_____

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

Email Address:_____ Work Phone: (_____) _____

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

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

**TRAVEL INFORMATION:**

Date Travel Arrangements were made:_____/_____/_____ Date of initial payment deposit: _____/_____/_____

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

**OTHER COVERAGE / AUTHORIZATION:**

Do you have any other type of coverage?_____

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

Type of Policy: _____Policy #: _____Contact: _____Phone: (_____) _____

Have you filed a claim with their office at this time? : Yes No

If yes, please note their response:_____

If not, why not:_____

**ILLNESS/ACCIDENT STATEMENT:**

Name of person having sickness or injury: _____His / Her date of birth: ____/___/____

Date Sickness or Injury began: _____/____/_____ Date First Treated: ____/____/____

Nature of Sickness or Injury (If Injury, describe accident, including date and place): _____
_____
_____

Period of hospitalization: From____/____/____ To: ____/____/____ Date ended: _____/_____/_____

Was there an accident report for this incident? _____ If Yes, please provide a copy.

Was there any previous treatment for this condition? _____ If Yes, please names of physician and dates of treatment:
_____
_____

**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.

- o 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
- o 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").
- o 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.
- o Airline Ticket Stub/Receipt (if applicable)
- o Copies of your credit card statements and/or cancelled checks showing your payment for the medical service submitted
- o 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
- o Other (please describe):_____

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

**EXPENSES CLAIMED:**

Please provide supporting documentation of the expenses you are claiming in addition to this claim form

| Name of Provider | Date Incurred | Amount of Bill | Amount Paid by Other Insurance | Amount Claimed |
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TOTAL AMOUNT CLAIMED $_____

I UNDERSTAND that it is illegal to knowingly file a false or fraudulent claim or to knowingly help someone else file one. I have read and understand the Fraud Notices on page 7 of this document.

_____ _____
Signed Date

## MAILING INSTRUCTIONS:

Send this form and any accompanying documentation to:

Attention: Co-ordinated Benefit Plans, LLC
On Behalf of XL Catlin
P.O. Box 20874
Tampa, FL 33622
Or
E-mail your information to: Team1@cbpinsure.com
Customer Service: 877-693-8530
Fax: 800-560-6340 or 727-499-9558

**Authorization For Release of Medical Information – To be Completed by Patient**

In order to process a claim for benefits, **I AUTHORIZE** any physician, hospital, or other Medical Provider to release to the Travel Insurance Claims Administrator, or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed two and one-half years from the date signed. I understand I have a right to receive a copy of this authorization.

Date: _____ **Signature**: _____
(Signature of Person Suffering Illness or Injury or legally authorized representative)