Safe Travels Claim Form and Insured Statement

Medical/Health

To help us process your claim quickly, please complete a separate claim form for each person and incident:

- Please make sure to sign each section where noted.
- If you would like to DESIGNATE a personal representative for us to talk about your claim, fill in Section C.
- Please send this fully completed form to Insurance Claims Administrator with ALL original bills and requested documents relating to the claim.
- Incomplete claims will be denied.
- NOTE: All submissions must be received within 90 DAYS of the loss or commencement of treatment.
- **Fraud Warning:** If the Insured Person or any person acting on his/her behalf shall make any claim or statement knowing the same to be false or fraudulent as regards amount, pre-existing conditions or otherwise, then this Insurance shall become void and all claims here under shall be forfeited without refund of premium.

A. INSURED INFORMATION	
Name (Last, First, MI):	
Date of Birth (MM/DD/YYYY):	National ID/Visa #:
Address:	
Postal Code:	Country:
Phone:	Email:
Policy #:	ID #:
Travel Destination:	Policy Purchase Date (MM/DD/YYYY):
Policy Effective Date (MM/DD/YYYY):	Policy Termination Date (MM/DD/YYYY):
Purpose of trip? ☐ Holiday ☐ Business ☐ Medical ☐ Other	
Was the assistance company contacted? ☐ Yes, my file number is: _____. ☐ No	
Do you have other medical insurance? ☐ Yes ☐ No If yes, please provide the carrier's name, address and policy insurance:	
FOR EU CITIZENS ONLY: Was a European Health Insurance Card (EHIC) taken on this trip? ☐ Yes ☐ No	
If yes, was the EHIC presented to the hospital or physician? ☐ Yes ☐ No If no, please explain:	
B. HOSPITAL & MEDICAL EXPENSES (Including prescriptions, x-rays, doctor visits, etc.)	
Accident/Illness Start Date (MM/DD/YYYY):	Accident/Illness First Treatment (MM/DD/YYYY):
Name of Physician/Facility first contacted:	
Address:	
Postal Code:	Country:
Email:	Phone:
Is the claim the result of an Illness? ☐ Yes ☐ No (if yes, please describe illness in detail)	
ILLNESS – Please describe symptoms, including the start date:	

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Is the claim the result of accident or injury? ☐ Yes ☐ No

Please describe accident in detail and include the place/time where the injury occurred:	
Was the accident or injury the result of playing a sport or due to a hazardous activity? ☐ Yes ☐ No (if yes, please describe)	
Address of Treating Physician/Facility:	
Physician/Facility Phone Number:	
If prior treatment was given in a hospital, as an inpatient, please provide Name, Address and Phone Number of Facility admitted to:	
Admit Date (MM/DD/YYYY):	Discharge Date (MM/DD/YYYY):
Did any physician prohibit you from traveling by air or otherwise due to this injury/illness? ☐ Yes ☐ No	
Were you traveling to receive medical treatment? ☐ Yes ☐ No If yes, list treatment, when you first learned of the alternative treatment and who recommended the treatment.	
Are you pregnant? ☐ Yes ☐ No If yes, indicate the number of weeks: _____.	
List prescription medicines you have been prescribed for your injury or illness. Include dosage and name of prescribing doctor.	

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List any prescription medicines, herbal medications or vitamins you are currently taking or took prior to your effective date that are not related to your injury/illness. Include dosage and name of prescribing doctor.
Is this a claim due to an unexpected recurrence of a pre-existing condition? ☐ Yes ☐ No (if yes, list name of physician currently treating this condition):
Patient Authorization for Release of Medical Information (To be filled out by Insured)
In order to process a claim for benefits, I authorize any physician, hospital, or other Medical Provider to release to Co-ordinated Benefit Plans, LLC,Trawick International, 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.

Signature:	Date (MM/DD/YYYY):

C. PERSONAL REPRESENTATIVE DESIGNATION (Optional)

YOUR RIGHTS UNDER FEDERAL LAW: You have the right to authorize that the confidential information held by Co-ordinated Benefit Plans, LLC and/or Trawick International be released to and/or received by persons or organizations you identify as indicated below with your signature. You are entitled, upon request, to receive a copy of this signed form.
I hereby authorize the request and release of my confidential information held to my personal representative. By appointing the person named below as my personal representative, I understand that I am authorizing to give this person access to my confidential information and medical records, the right to talk to about my medical care and the right to make decisions that will bind me. I agree that a photocopy, e-mailed copy or facsimile (FAX) copy of the authorization shall be accepted and as valid as the original.
This "PERSONAL REPRESENTATIVE DESIGNATION" is subject to revocation at any time except to the extent that action has been taken in reliance hereon and, if not earlier revoked in writing, it shall remain valid for two (2) years from date of signature.

Name (Last, First, MI):	
Date of Birth (MM/DD/YYYY):	Relationship:
Address:	
Postal Code:	Country:
Phone:	Email:
Insured Signature:	Date:
Personal Representative Signature:	Date:

D. 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. Please keep copies of any items submitted with this claim.

☐ Medical bills, including prescription information and receipts, medical records
☐ Passport showing names, locations and stamps, 1-94
☐ Proof of Travel - (Airline ticket stub/receipt)
☐ Other:

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E. REIMBURSEMENTAUTHORIZATION AND METHOD

I hereby authorize Co-ordinated Benefit Plans, LLC to mail any payments to the below listed address and to deposit any amounts owed me for reimbursement of medical expenses or services rendered by initiating credit entries to my account at the financial institution (hereby BANK) indicated above. Further, I authorize BANK to accept and to credit any credit entries indicated by Company to my account. In the event that Company erroneously deposits funds in my account (by way of example, I am not entitled to the funds or the amount of deposit Is incorrect or such funds are deposited in the wrong account), I authorize Company to debit or credit my account in the amount necessary to correct the initial deposit, but in no case shall any debit exceed the amount of the initial deposit. I further agree Company is not responsible for any transaction fees charged and will release Co-ordinated Benefit Plans, LLC of any liability in the event of lost or stolen payments. I authorize Co-ordinated Benefit Plans, LLC to contact me using the email address I provided in this form to discuss and/or inform me of payment confirmation.

Account Holder Signature:	Date:

☐ Check to Insured's Address, as listed in INSURED INFORMATION section.

☐ Check to other Mailing Address:

☐ Send by Electronic Direct Deposit (U.S. banks only)

Bank Name:

Name on Account:

Account #/IBAN:

Routing #/ABA # (for Electronic Direct Deposit):

F. FRAUD NOTICE/AUTHORIZATION

F-1: Fraud Notice

General: 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.
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.
Arizona: 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.
Arkansas, Louisiana, Maryland, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
California: 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.
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 member for the purpose of defrauding or attempting to defraud the policyholder or member 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.
Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.
Delaware, Idaho, Indiana: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
District of Columbia: 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.
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.
Hawaii: 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.

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F-1: Fraud Notice (continued)

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.
Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.
Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another person files a 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 the person to criminal and civil penalties.
Minnesota; A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.
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 Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal 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.
Ohio: Any person who, with intent to defraud or knowing that he 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.
Oklahoma: 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.
Oregon: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.
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.
Tennessee, Virginia, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
Texas: 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.

F-2: Authorization

I AUTHORIZE any insurance company, physician, hospital, and other health care providers, or any other person who may have knowledge regarding this claim, to release any information requested regarding this claim and the loss reported. I UNDERSTAND the information obtained by use of the authorization, will be used by Co-ordinated Benefit Plans, LLC /Trawick International to determine eligibility for benefits under this plan. Any information obtained wil l not be released by Co-ordinated Benefit Plans, LLC/Trawick International to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I further authorize. I KNOW that I may request to receive a copy of the Authorization. I AGREE that a photographic copy of this authorization is as valid as the original. I AGREE that this Authorization shall be valid for two and one half years from the date shown below. 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.

Insured Signature:	Date (MM/DD/YYYY):
Parent Signature (if Insured is a minor):	Date (MM/DD/YYYY):

Please send completed form and supporting documents to
Email: GBGclaims@cbpinsure.com **Fax:** 866-616-0444
Mail: Co-ordinated Benefit Plans, LLC on Behalf of Global Benefits Group
PO Box 2069
Fairhope AL 36533

For claim status:
U.S./Canada toll-free: 866-669-9004
Local: 251-928-0939
Email: GBGclaims@cbpinsure.com