# Cultural Insurance Services International - Claim Form

**Underwritten by The Insurance Company of the State of Pennsylvania**

**Instructions**

1. Complete a medical claim form for each occurrence indicating whether the Doctor/Hospital has been paid.
2. Sign consent below.
3. Attach *itemized bills* for all amounts being claimed (include originals and keep copies for yourself).
4. Approved reimbursements will be paid to the provider of the service unless otherwise indicated.
5. **Submit claim form and attachments to Cultural Insurance Services International, River Plaza, 9 West Broad Street, Stamford, CT 06902-3788.**

- Payment will be made in US dollars unless otherwise requested. If payment is made to you, it will be made to your US address unless otherwise requested.
- **For claim submission questions, call (203) 399-5130 or email claimhelp@culturalinsurance.com.**

## ►PROGRAM NAME OR POLICY NUMBER: ____________________________________________________

### ► NAME AND CONTACT INFORMATION OF INSURED

*Last Name ___________________________________ *First Name _____________________________*Date of Birth_______/________/________

Identification Number _________________________

US Address or Address Abroad ____________________________________________________________________________________________

*Home Country Address _______________________________________________________________________________________________

Phone Number ____________________________ *Email address _________________________________________________________________

*Date insured expects to return to home country _________/__________/___________

**(*required fields)**

### ► IF IN AN ACCIDENT

Date, Time, and Place of Accident (a.m. or p.m.)__________________________________________________________________________________

Description/Details of Injury ______________________________________________________________________________________________

What happened? ____________________________________________________________________________________________________

### ► IF SICKNESS

Description of Sickness/Illness ____________________________________________________________________________________________

Date Illness Commenced _______/__________/___________ Date you Plan to Return Home ________/__________/___________

### ► REIMBURSEMENT

Have these doctor/hospital bills been paid by you? □ YES □ NO

If no, do you authorize payment to provider of service for medical services claimed? □ YES □ NO

### ► FOR CLAIMS UNRELATED TO A MEDICAL INCIDENT, PLEASE CHECK THE APPROPRIATE BOX BELOW:

*(Please note: In order to claim monies back related to one of the below benefits, the benefit(s) MUST be included in your policy. If you try to make a claim for a benefit which you do not have, the claim will be denied)

**□TUITION REFUND/SESSION INTERRUPTION □RETURN AIRFARE EXPENSE/PROGRAM FEE REFUND □PERSONAL EFFECTS-**
Personal effects claim submissions MUST be accompanied by police report

Please provide us with the relevant details of your incident below or the details and value of your loss:

________________________________________________________________________________________________________________

________________________________________________________________________________________________________________

### ► CONSENT TO RELEASE MEDICAL INFORMATION

I hereby authorize any insurance company, Hospital or Physician to release all of my medical information to CISI that may have a bearing on benefits payable under this plan. I certify that the information furnished by me in support of this claim is true and correct.

Name (please print) ______________________________________________________________________________

Signature __________________________________________________________________ Date_________________________

**For residents of 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.

**For residents of New York**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 subject motor vehicle or stated claim for each such violation.

**For residents of Pennsylvania**: 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 and subjects such person to criminal and civil penalties.

**For claimants not residing in California, New York, or Pennsylvania**: 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.