CLAIMS SUBMISSIONS & QUESTIONS

SUBMIT A CLAIM BY:

Online Portal: https://www.mycisi.com/ParticipantPortal

Email: submityourclaim@mycisi.com

Mail: 1 High Ridge Park, Stamford, CT, 06905

Fax: (203) 399-5596

SUBMIT A CLAIM ONLINE

ONLINE PORTAL: https://www.mycisi.com/ParticipantPortal

- **If you created a login already**, select I am "Insured". Then enter your Username and Password.
- **If you have not created a login**, Click on the "click here" button to create an account.

1. Go to the **Claim Info & Submission** tab.
2. Click on **Submit a Claim & check the Status Online**.
3. Click on **Submit a Claim** and follow the prompts.
4. Check **claim status** once you've submitted a claim.

SUBMIT A CLAIM BY EMAIL, MAIL OR FAX

STEP 1 — COMPLETE CLAIM FORM

Fully complete and sign the medical claim form for each occurrence, indicating whether the Doctor/Provider has been paid.

STEP 2 — INCLUDE ITEMIZED BILLS & DOCUMENTATION

Attach itemized bills for all amounts being claimed and documentation. *If mailing, we recommend you provide us with a copy and keep the originals yourself.

STEP 3 — SUBMIT CLAIM

You can submit claims by:

Mail: 1 High Ridge Park, Stamford, CT, 06905

Email: submityourclaim@mycisi.com

Fax: (203) 399-5596

How long will it take to be reimbursed for eligible medical expenses paid out-of-pocket?

Turnaround for claim payments is generally 15 business days from receipt date. To check the status of your claim, contact CISI at (800) 303-8120 from 9AM to 5PM EST.

I received a bill from a medical provider. What do I do?

The bill may be for your deductible. Review the charges and see if CISI made a payment on your behalf. The balance may be your responsibility.

If you do not have a deductible in your plan, or have already paid this amount, submit the bill to CISI. Include a completed claim form pertaining to your doctor's visit and proof of payment to be reimbursed for any coverable expenses.

I got a letter from CISI asking for more information. What do I do?

The claims team may send you an email asking you to complete a claim form if it was not provided with your initial submission or was not completed correctly. Complete the claim form and send it back to the submityourclaim@mycisi.com email address. The claims team may need additional documentation that was not submitted with the initial claim. Please email submityourclaim@mycisi.com the information is requesting in order to process the claim or log into your Participant Portal and upload via the Claim Info & Submission tab.

How long do I have to submit a claim?

You can submit a claim within a year of the Date of Service.

Where can I access additional claim forms?

On the next page, but it's also provided at the end of your brochure, attached to your welcome email, our website mycisi.com & on the myCISI Participant Portal.

Approved reimbursements will be paid to the provider of the service unless otherwise indicated on the form.
For claim submission questions, call (203) 399-5130, or email inquiries@mycisi.com.
Claims should be submitted for processing as soon as possible (and no later than one year after treatment was received).

Cultural Insurance Services International – Claim Form

(Applicable to claim submissions via email, mail or fax)

- **Group Sponsor Name:** COLORADO SCHOOL OF MINES
- **Policy Number:** 26 GLM N16816826
- **Participant ID Number** (from the front of your insurance card)**:** _____

Mailing Address: **1 High Ridge Park, Stamford, CT 06905 | *E-mail:* submityourclaim@mycisi.com | *Fax:* (203) 399-5596**

Questions? Call (203) 399-5130 *or* e-mail inquiries@mycisi.com

INSTRUCTIONS:

1. **Fully complete** and sign the medical claim form for each occurrence, indicating whether the Doctor/Hospital has been paid.
2. Attach **itemized bills** for all amounts being claimed. *We recommend providing us with a copy and keep the originals for yourself.
3. Approved reimbursements will be paid to the provider of the service unless otherwise indicated.
4. Submit claim form and attachments via mail, e-mail, or by fax (provided above).

See pages 2-3 for state specific disclaimers, claimant cooperation provision and additional claim submission instructions.

***IMPORTANT - MUST READ BEFORE PROCEEDING:** If your claim pertains to an Accident, SECTION 2 MUST be completed. If your claim pertains to a Sickness/Illness, SECTION 3 MUST be completed. Failure to complete one of these sections (whichever section pertains to your claim), will cause a delay as we will request that you complete this form again to include this necessary information in order to process your claim. For claims related to one of the Travel Assistance Benefits, see Section 5.

SECTION 1: NAME AND CONTACT INFORMATION OF THE INSURED (REQUIRED)

Name of the Insured:_____ Date of Birth: _____/_____/_____
(month/day/year)

*Please indicate which is your home address: ☐ U.S. Address ☐ Address Abroad

U.S. Address:_____
street address apt/unit # city state zip code

Address Abroad: _____

E-mail Address: _____ Phone Number: _____

SECTION 2: IF IN AN ACCIDENT***

Date of Accident:_____/_____/_____ Place of Accident: _____ Date of Doctor/Hospital Visit:_____/_____/_____

Description/Details of Injury *(attach additional notes if necessary)*:_____

_____

SECTION 3: IF SICKNESS/ILLNESS***

Description of Sickness/Illness *(attach additional notes if necessary)*:_____

Onset Date of Symptoms: _____/_____/_____ Date of Doctor/Hospital Visit: _____/_____/_____

Have you had this Sickness/Illness before? ☐ YES ☐ NO If yes, when was the last occurrence and/or doctor/hospital visit? _____

SECTION 4: REIMBURSEMENT***

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

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

If yes, you must include the payment receipt(s). Any eligible reimbursements will be made in U.S currency (USD) via check. If you would like your eligible reimbursement in another currency via wire transfer, please contact CISI at 203-399-5130 or inquiries@mycisi.com for instructions.

Please note if you are submitting a claim for prescription medication, you must submit the prescription receipt. This will include your name, the name of the prescribing physician, name of the medication, dosage, date and amount billed. Cash register receipts will not be considered for reimbursement.

SECTION 5: FOR CLAIMS UNRELATED TO A MEDICAL INCIDENT PLEASE CHECK THE APPROPRIATE BOX BELOW:

In order to claim monies back related to one of the below benefits, you **MUST** submit the requested documentation found on the following page **(Page 2)**.

☐ Trip Cancellation ☐ Trip Delay ☐ Trip Interruption ☐ Quarantine ☐ Emergency Medical Reunion

Please provide us with the relevant details of your incident below or the details and value of your loss. You may attach an additional page if necessary:

_____

STOP! Please see next page for claim submission instructions specific to each of these benefits.

SECTION 6: CONSENT TO RELEASE MEDICAL INFORMATION

I hereby authorize any insurance company, Hospital or Physician or other person who has attended or examined me, including those in my home country to furnish to Cultural Insurance Services International or any of their duly appointed representatives, any and all information with respect to any sickness/illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical reports. A photo static copy of this authorization shall be considered as effective and valid as the original.

I certify that the information furnished by me in support of this claim is true and correct.

Name (please print): _____

Signature: _____Date:_____

Instructions for Claim Submission on Unrelated to a Medical Incident

Quarantine, you must submit:

- Proof of positive test performed by a medical professional or laboratory.
- Proof of Quarantine requirement:
  a) If required by treating physician/medical authority, a letter must be from the treating physician.
  b) If required by local government officials or authorities, a letter must come from the governmental official or authority. If individual letters are no longer being issued in the country of destination, provide proof of government requirement via verifiable source (i.e. local government website, etc).
  c) If no local government guideline exists but insured is unable to travel back to the US due to the airline's adherence to CDC travel guidelines requirements, specify this clearly on claim form and include original flight itinerary.
- Proof of negative test or date of recovery paperwork, showing you can travel again.
- Receipts for any eligible expense.
- Proof of non-refundable expenses.

Trip Cancellation, you must submit:

- Proof of non-refundable expenses must be provided.
- Proof of Payment.
- Letter stating reason for not traveling (if due to a medical condition, a detailed letter must be from the treating physician).

Trip Delay, you must submit:

- Proof of delay.
- Receipts for any eligible expense.

Trip Interruption, you must submit:

- Proof of Payment.
- Flight Itinerary including your name, travel dates and departure and arrival locations.
- Letter stating reason for curtailing travel (if due to a medical condition, the letter must be from the treating physician).
- If death of a family member, obituary or a copy of the death certificate is required as proof.

Emergency Medical Reunion, you must submit:

- Proof of hospitalization, or if Felonious Assault, a report.
- Flight itinerary.
- Hotel Invoice.
- Meal Receipts.

The Plan is underwritten by ACE American Insurance Company and administered by Cultural Insurance Services International.

Claimant Cooperation Provision:

Failure of a claimant to cooperate with Us in the administration of a claim may result in the termination of a claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

For residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution or confinement in prison, or any combination thereof.
For residents of 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.
For residents of Arkansas, Louisiana, 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.
For residents of 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.
For residents of 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 within the department of regulatory agencies.
For residents of Delaware, Idaho: 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.
For residents of District of Columbia: 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.
For residents of 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.

For residents of Kansas: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

For residents of Kentucky: 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 crime.

For residents of Maine, Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an Insurance Company for the purpose of defrauding the Company. Penalties include imprisonment, fines and denial of insurance benefits.

For residents of Maryland: Any Person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit, or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For residents of 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.

For residents of 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.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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 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.

For residents of 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.

For residents of Oklahoma: 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.

For residents of Oregon: Any person who knowingly, and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud.

For residents of Pennsylvania: Any person who knowingly and with the 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.

For residents of Rhode Island: 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.

For claimants not residing in Alabama, Alaska, Arizona, Arkansas, California, Colorado, District of Columbia, Delaware, Florida, Idaho, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Virginia Washington nor West Virginia: Any person who, knowingly presents a false or fraudulent claim for payment of 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.

For residents of 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. For the purposes of this section, "claims form" means any document supplied by an insurer to an insured, claimant or other person that the insured, claimant or other person is required to complete and submit in support of a claim for benefits.