Cultural Insurance Services International – Claim Form

- **Program Name:** Au Pair in America
- **Policy Number:** 23 GLM N04965231
- **Participant ID Number** (from the front of your insurance card)**:**

Mailing Address: **1 High Ridge Park, Stamford, CT 06905 |** ***E-mail:*** **claimhelp@mycisi.com |** ***Fax:*** **(203) 399-5596**
For claim submission questions, call (203) 399-5130 *or* e-mail claimhelp@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 you provide 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 next page for state specific disclaimers, claimant cooperation provision and additional claim submission instructions.

*****IMPORTANT:** 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 for you to 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

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 claimhelp@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 INTERRUPTION** ☐ **PERSONAL PROPERTY** ☐ **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:_____

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Instructions for Claim Submission on Unrelated to a Medical Incident

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.

Personal Property and Effects, you must submit:

- Itemized listing of items lost or stolen with approximate values at the time of loss.
- Police Report or report and response from transportation carrier.

Emergency Medical Reunion, you must submit:

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

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 Arkansas, Louisiana, 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 fines and confinement in prison.

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 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 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 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 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 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 claimants not residing in Alabama, Arkansas California, Colorado, District of Columbia, Florida, Kansas, Kentucky, Louisiana, Maine, Maryland, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Virginia nor Washington: 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.

Proof of Loss/Claims Reporting	Mail or Fax to:	Claim Number
Phone: (203) 399-5130 Fax: (203) 399-5596	Cultural Insurance Services International 1 High Ridge Park Stamford, CT 06905	
		Policy No./Cert. No.

Insured Name:	Home Phone:	Work Phone:
E-mail address:	Cell Phone:	Fax:
Present Address:		
Mailing Address:		
How did the loss happen?		
Date of loss:	Time of loss:	
Location of loss:		

Policy Report/Security Report:

- Where made(address/police precinct no./security company): _____
  _____
  (city) (country) Date:_____

- What police action was taken? _____
  _____

Please Enclose Police Report For Theft Or Robbery

Description of Article	Nature and Extent of Damage	Date of Purchase	Original Cost	Amount Claimed
				Total:

Please attach all important information (i.e. receipts, photographs, carrier documents, appraisals,etc.)

The property described on this claim form is either owned by myself or an immediate family member. The losses/damages to said property did not exist prior to my move and in no way were caused by me or any member of my family. All statements made in this Statement of Claim and any attached documents are true, correct and complete to the best of my knowledge and belief. I understand that if I make any material misrepresentation or withhold any material information concerning my claim, I will not be entitled to payment and may be subject to termination of employment. I further understand that my entire file may be audited at any time.

_____ _____

Employee Signature **Date**