Cultural Insurance Services International – Claim Form

- **Program Name:** American University of Rome
- **Policy Number:** 24 CC010502
- **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).

***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 Emergency Medical Reunion Benefit, 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 RELATED TO THE EMERGENCY MEDICAL REUNION

In order to claim monies back related to one of the Emergency Medical Reunion benefit, you **MUST** submit the following:

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

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:

_____

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:_____

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.

This plan is underwritten by Crum & Forster SPC and administered by Cultural Insurance Services International.