



# Cultural Insurance Services International – Claim Form

- ▶ **Program Name:** AIFS Customized, Faculty-Led Programs
- ▶ **Policy Number:** 24 CC009952-LT
- ▶ **Participant ID Number** (from the front of your insurance card):

**Mailing Address:** 1 High Ridge Park, Stamford, CT 06905 | **E-mail:** [claimhelp@mycisi.com](mailto:claimhelp@mycisi.com) | **Fax:** (203) 399-5596  
 For claim submission questions, call (203) 399-5130 or e-mail [claimhelp@mycisi.com](mailto: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 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. For claims related to one of the Travel Assistance Benefits, see Section 5. 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.*

## 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](mailto: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 DELAY  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 Delay, you must submit:**

- Proof of delay.
- Receipts for any eligible expense.
- *If delayed due to Quarantine:*
  - 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 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.

This plan is underwritten by Crum & Forster SPC 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.