



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

► **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.