P.O. Box 88503
Indianapolis, IN 46208-0503
T: (866) 243-7524
(317) 655-9798
F: (317) 655-4505

# EMERGENCY MEDICAL/HOSPITAL/DENTAL OR EVACUATION/REPATRIATION CLAIM FORM

**Instructions: Failure to supply complete information may delay your claim process!**

1. Complete and sign the claim information form below.
2. Attach all original, itemized bills if you have no other insurance coverage. There must be records indicating the diagnosis and the procedures performed.
3. If you have another medical insurance policy, you must file a claim with your primary insurer first. Once you have done so, please attach a copy of the Explanation of Benefits from your Primary Insurer along with a copy of the original bill.
4. **Sign where indicated on the Certificate of Medical History Letter where it states, "Patient's Signature". We must have your signature on file in order to obtain additional medical information if needed.**
5. Attach a copy of any medical report/records from the treating physician(s) or dentist.

**Emergency medical, hospital and dental benefits are secondary to any other coverage you may have. Before your claim can be considered, you must file with your primary carrier first, before filing with us. Your claim will be reduced by any payments made to you. This provision is waived if you made other arrangements directly with the iTravelInsured Assistance Company while on your trip. All Evacuation/Repatriation claims must be pre-approved by iTravelInsured. Failure to obtain pre-approval may result in reduced benefits or denial of your claim.**

## Information about You and Your Claim

**Name of Insured person and all persons traveling with you covered under this policy**:

1)_____ Date of Birth: ____/____/____

2)_____ Date of Birth: ____/____/____

3)_____ Date of Birth: ____/____/____

4)_____ Date of Birth: ____/____/____

**Present Address**: _____

**City, State, and Zip**: _____

**Home Telephone**: _____ **Work Telephone**:_____

**Name and telephone of Travel Agency from whom you purchased your trip**:

_____

**Your Scheduled Departure Date**: _____**Your Scheduled Return Date**:_____

**Your Travel Insurance Certificate #**: _____ (This is on your travel insurance receipt)

Describe your illness or injury? _____

When did illness/injury first occur on your trip? _____

Dates of treatment? From: _____ To: _____

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Had you received treatment for this illness/injury before you went on your trip? _____, If yes, please explain:

_____

_____

Name, address & telephone of physician(s) or facility where you were seen?

_____

_____

_____

Name, address & telephone of physician(s) or facility that have seen you prior to the trip?

_____

_____

_____

To calculate your claim:

Total Amount of Medical Bills: $_____

Less: Payment by Primary Insurer: - _____

Total Out-of-Pocket Loss: $_____

**Please be sure to attach a copy of all medical provider bills and any Explanation of Benefit payments or non-payment from your primary medical insurance provider(s).**

**I/We attest that all the information submitted is true and accurate to the best of our knowledge. Furthermore, I/We agree that this insurance shall be void if, whether before or after the loss/incident, any person has concealed or misrepresented any fact or circumstance concerning this claim. The signatures of all parties that are party to this claim appear below**

_____ _____
(Signature of Claimant) (Date: mm/dd/yyyy)

_____ _____
(Signature of Claimant) (Date: mm/dd/yyyy)

**Please mail your completed, signed form back to the claims administrator along with all of your documentation. Be sure to include itemized receipts for other expenses incurred (hotel, meals, etc). This documentation is your proof of loss and is required in order to finalize your claim.**