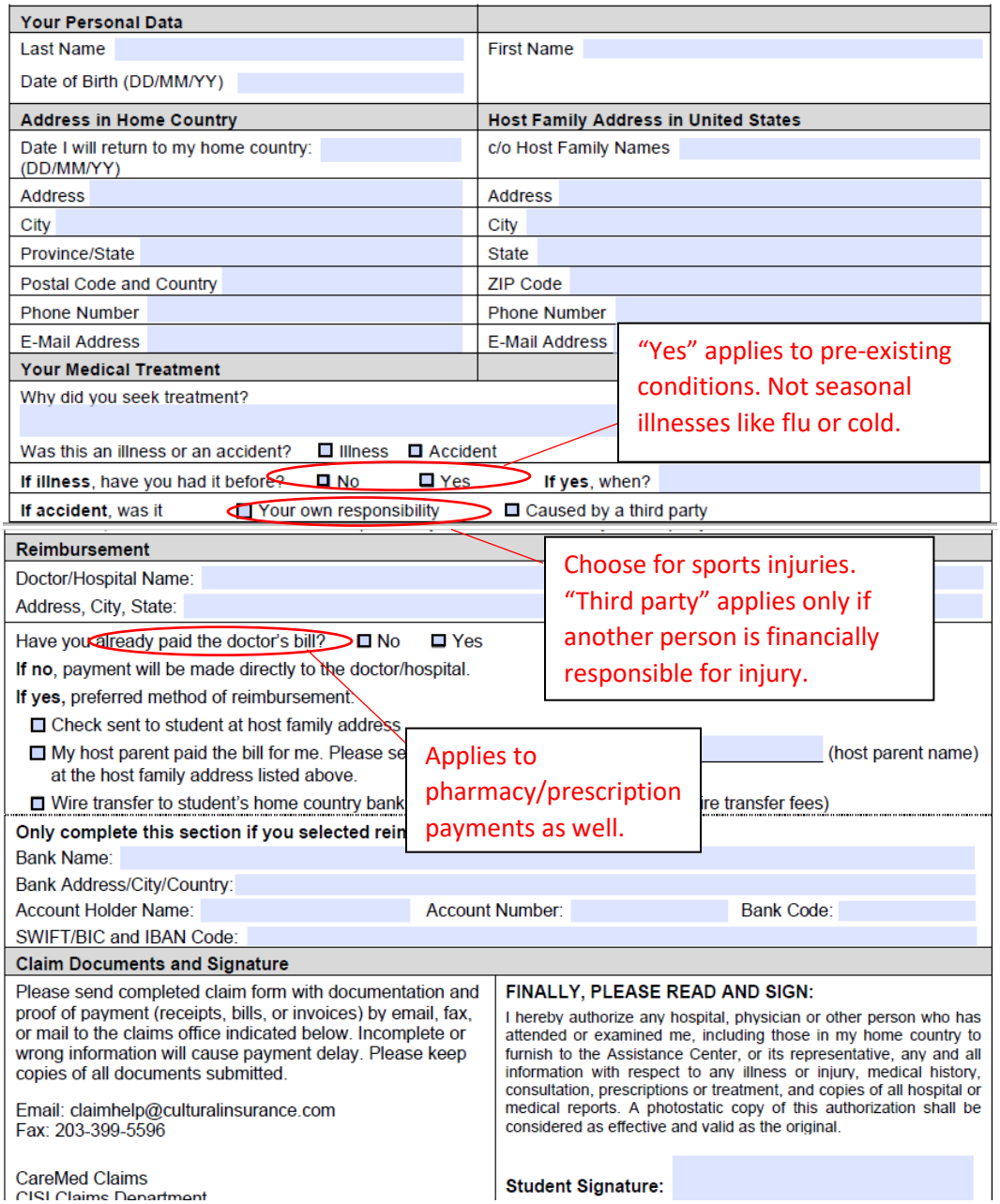
Completing a CareMed Claim form

➔ For every upfront payment, a claim form needs to be completed.



Your Personal Data

Last Name | First Name

Date of Birth (DD/MM/YY)

Address in Home Country	**Host Family Address in United States**
Date I will return to my home country: (DD/MM/YY)	c/o Host Family Names
Address	Address
City	City
Province/State	State
Postal Code and Country	ZIP Code
Phone Number	Phone Number
E-Mail Address	E-Mail Address

Your Medical Treatment

Why did you seek treatment?

Was this an illness or an accident? ☐ Illness ☐ Accident

If illness, have you had it before? ☐ No ☐ Yes **If yes**, when?

If accident, was it ☐ Your own responsibility ☐ Caused by a third party

"Yes" applies to pre-existing conditions. Not seasonal illnesses like flu or cold.

Choose for sports injuries. "Third party" applies only if another person is financially responsible for injury.

Reimbursement

Doctor/Hospital Name:

Address, City, State:

Have you already paid the doctor's bill? ☐ No ☐ Yes

If no, payment will be made directly to the doctor/hospital.

If yes, preferred method of reimbursement.

☐ Check sent to student at host family address

☐ My host parent paid the bill for me. Please se _____ (host parent name) at the host family address listed above.

☐ Wire transfer to student's home country bank ire transfer fees)

Applies to pharmacy/prescription payments as well.

Only complete this section if you selected rein

Bank Name:

Bank Address/City/Country:

Account Holder Name: Account Number: Bank Code:

SWIFT/BIC and IBAN Code:

Claim Documents and Signature

Please send completed claim form with documentation and proof of payment (receipts, bills, or invoices) by email, fax, or mail to the claims office indicated below. Incomplete or wrong information will cause payment delay. Please keep copies of all documents submitted.

Email: claimhelp@culturalinsurance.com
Fax: 203-399-5596

CareMed Claims
CISI Claims Department

FINALLY, PLEASE READ AND SIGN:

I hereby authorize any hospital, physician or other person who has attended or examined me, including those in my home country to furnish to the Assistance Center, or its representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical reports. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Student Signature: