Travel medical expense claim form

Travel insurance products sold by UnitedHealthcare Global are underwritten by Centurion Casualty Company or H&W Indemnity SPC for and on behalf of Global Solutions SP. Please complete this form to make a travel insurance claim.

Claimant's information

Account name and policy number				
Name of claimant				
Address	City	State	Postal code	Country
Email address	Home phone (include country code)	Cell phone (include country code)		

Legal guardian information (if claimant is under the age of 18)

Full name	
Mailing address	
Relationship to claimant	
Home phone	Cell phone
Email address	
Signature of claimant's legal guardian	

Note: Your signature indicates you are the legal guardian of the claimant and authorizes payment issuance to you.

Travel supplier/provider information

Name of tour operator/cruise line/airline you were traveling with	
Scheduled date of departure	Scheduled date of return
Origination	Destination
Flight number	Flight number
Air carrier	Air carrier

continued

Other insurance/authorization

Do you have any other type of insurance? ☐ Yes ☐ No

If yes, please provide the company name and address

Type of policy	Policy number	Contact	Phone (include country code)

Details of sickness/injury

Date sickness or injury began	Date of first treatment

Nature of sickness/details of accident

Have you ever been treated for this condition previously? ☐ Yes ☐ No	Date(s) of treatment(s)

Treating physician(s) information

1. Physician's name	Phone (include country code)

Address

2. Physician's name	Phone (include country code)

Address

AUTHORIZATION: I hereby authorize Centurion Casualty Company, H&W Indemnity SPC for and on behalf of Global Solutions SP or its representative, to inspect or secure copies of case history records or any other data necessary to determine eligibility of benefits. I also authorize Centurion Casualty Company, H&W Indemnity SPC for and on behalf of Global Solutions SP or its representative to release and share claim information including that which may be used in the identification and prevention of potential fraudulent activity to any insurance organization, fraud information clearinghouses, designated service providers and business associates assisting in the processing of this claim. A photostatic copy or facsimile of this authorization shall be deemed as effective and valid as the original. This authorization is valid for twelve (12) months from date of signature. **I HAVE REVIEWED AND ACKNOWLEDGE THE ATTACHED FRAUD WARNING.**

Signature of insured	Date

Claim documentation requirements

Depending upon the circumstance involved in the loss, one or more of the following items may be required to complete the processing of your claim. Please place a check by those items you have attached. We recommend you keep copies of any items submitted with this claim.

- ☐ Copies of itemized bills and/or statement from medical providers for services rendered in connection with your claim. These bills and/or statements must include the date of service, the service rendered, the charge for each service, and the diagnosis.
- ☐ If you have other insurance, we need the final disposition from the primary insurer listing payment or denial of your claim with them (Explanation of Benefit or "EOB")
- ☐ Copies of the front and back of your cancelled checks and/or your credit card statements showing your payments for the trip; and a copy of your trip invoice
- ☐ Airline ticket stub/receipt (if applicable)
- ☐ Copies of your credit card statements and/or cancelled checks showing your payment for the medical service submitted
- ☐ If medical expenses were incurred abroad, attach copies of your passport pages which identify you as the traveler and document your entrance into and exit from the country or countries where medical services were received

Other (please describe)

continued

Itemized claims				
Item(s)	**Estimated value**	**Have you received reimbursement?**	**If so, from whom?**	**How much?**
	$	☐ Yes ☐ No		$
	$	☐ Yes ☐ No		$
	$	☐ Yes ☐ No		$
	$	☐ Yes ☐ No		$
	$	☐ Yes ☐ No		$
	$	☐ Yes ☐ No		$
	$	☐ Yes ☐ No		$
	$	☐ Yes ☐ No		$
	$	☐ Yes ☐ No		$
Total	$			$

Mailing instructions

Please complete this form in full and return to:
Attention: Co-Ordinated Benefit Plans, a subsidiary of One80 Intermediaries
On Behalf of Centurion Casualty Company or H&W Global Solutions Segregated Portfolio SP
P.O. Box 26222
Tampa, FL 33623

OR

Email to: **UHCSafeTripClaims@cbpinsure.com**
Customer Care: **1-877-693-8530**

Consent to receive all communications electronically

Please be advised, our preferred method of communication with you is electronically by email. Use of email helps us provide better and faster service. Please provide your consent to this in the area below. We will keep this on file with your claim.

Expressed consent to receive all communications electronically:

I agree to receive all mailings and communications electronically

I have read and agree to the **terms and conditions** of the electronic delivery*

I accept ☐ Yes ☐ No

Please confirm the preferred email address:

Email address _____

*Click the terms and conditions above to review online, or download a copy by typing the below URL into your internet browser.
http://policydocuments.tpaproducts.com/EDOD/consent.pdf

continued

Important Notice

Fraud Warning: Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

Notice to District of Columbia Claimants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Notice to Kentucky Claimants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

Notice to Maine Claimants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Notice to Maryland Claimants: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Minnesota Claimants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Notice to New Hampshire Claimants: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

Notice to New Mexico Claimants: 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 CIVIL FINES AND CRIMINAL PENALTIES.

Notice to Oklahoma Claimants: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

Notice to Pennsylvania Claimants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

Notice to West Virginia Claimants: 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.

Please maintain a copy of this document for your records.

06/24 SFT-MBR-1312851-Claims-TM

United Healthcare Global