CISI
Cultural Insurance Services International

CLAIM FORMS

Below you will find 2 forms:

1. **Medical Claim Form:**
The first form is your medical claim form, labeled "Rotary Youth Exchange N0106096A" (first page only)

Please submit all medical bills/receipts with the Rotary Youth Exchange claim form to:

CISI-Bolduc
River Plaza
9 West Broad St.
Stamford, CT 06850
USA

2. **Personal Liability Claim Form**:
The second form (beginning on page 2) is your personal liability claim form, which consists of 4 pages

Please submit all personal liability claim forms with attached reports (depending on the situation); a police report, itemized receipts, home owners insurance declaration page, or description of items to

CISI-Bolduc
River Plaza
9 West Broad St.
Stamford, CT 06850
USA

Please contact CISI for any questions at 1-800-303-8120 ext 5556

Cultural Insurance Services International - Claim Form

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.**

► NAME AND CONTACT INFORMATION OF INSURED

POLICY: ROTARY YOUTH EXCHANGE N0106096A

*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

► FOR CLAIMS UNRELATED TO A MEDICAL INCIDENT, PLEASE CHECK THE APPROPRIATE BOX BELOW:

*(Please note: In order to claim monies back related to one of the below benefits, the benefit(s) MUST be included in your policy. If you try to make a claim for a benefit which you do not have, the claim will be denied)

□**TUITION REFUND/SESSION INTERRUPTION** □**RETURN AIRFARE EXPENSE/PROGRAM FEE REFUND** □**PERSONAL EFFECTS-** Personal effects claim submissions MUST be accompanied by police report

Please provide us with the relevant details of your incident below or the details and value of your loss:

_____

_____

► 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.

For residents of Rhode Island: 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.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

For residents of Florida: Any person who knowingly and with intent in injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

For Residents of Maryland/Oregon: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

For Residents of Virginia: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may have violated state law.

Personal Liability Claim Form

CISI-Bolduc
River Plaza
9 West Broad St
Stamford, CT 06902
1-800-303-8120
Fax: 203-399-5556

THANK YOU FOR NOTIFYING US OF YOUR CLAIM
PLEASE COMPLETE **ALL** QUESTIONS - IF ANY QUESTION IS NOT APPLICABLE PLEASE STATE AN/A≅

Schedule of Benefits for Liability Coverage Underwritten by ACE American Insurance Company

Name of Insured
Policy No: N0106096A

Full Name of Covered Person: (Mr., Mrs., Miss, Ms)	Date of Birth:
Full Address:	Zip/Postal Code:
Tel No. (Business):	(Home):
E-Mail Address:	

TRAVEL DETAILS
Type of Travel: Rotary Youth Exchange
Please give date of loss/damage/theft: In which country did the loss/damage/theft occur:
Please give full details of the loss/damage/theft:
To whom was the loss/damage/theft reported? (Please see notes below and provide a copy of this report) On which date was the loss/damage/theft reported?
If article(s) lost/stolen: What steps were taken regarding recovery of the article(s)? Please provide any written evidence **If article(s) damaged:** Please supply estimates for cost of repairs or a letter from a reputable dealer confirming irreparably damaged.

Please supply receipts - if not available please supply replacement estimates/invoices.

Is any property lost/damaged/stolen insured by any other company? YES/NO

If YES, please supply name, address, telephone number and policy number:

Please supply name, address, telephone number and policy number of homeowners/household contents insurers:

Have you had any previous claims on this type of insurance? YES/NO

If YES, please give full details with relevant dates:

Notes:

1. All losses should be reported to the local police and a report obtained. This should be forwarded to CISI-Bolduc.

2. All losses or damaged property which occurred while in the custody of an airline should be reported and a Property Irregularity Report Form obtained. This should be forwarded to CISI-Bolduc together with the ticket stubs.

PLEASE ENSURE THE APARTICULARS OF CLAIM FORM IS FULLY COMPLETED AND ATTACHED.

DECLARATION

I declare that all the information given is to the best of my knowledge and belief, full, true and correct.

Signed:_____ Date:_____

PLEASE ENSURE (/)

You have completed ALL relevant questions on this claim form.

You have enclosed all requested information/documentation and the AParticulars of Claim≅ form.

You have signed this claim form.

Failure to do so will result in delay in handling your claim.

Please return the completed claim forms together with any enclosures to your Insurance Broker or to ACE USA at the address shown.

Thank you for fully completing this form.

Mail to: CISI
River Plaza
9 West Broad St
Stamford, CT 06902

PARTICULARS OF CLAIM

Full description of each item of property lost, damaged or stolen	State to whom property belonged	Date of Purchase	Original Cost Price		Receipts/ Replacement Estimates Attached (*I*)

TOTAL SUM CLAIMED

PLEASE ENSURE YOU PROVIDE RECEIPTS IF POSSIBLE OR REPLACEMENT ESTIMATES FROM A REPUTABLE RETAILER FOR ITEMS $150.00 OR OVER

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

- I *agree* that a photographic copy of this Authorization shall be a valid as the original.
- I understand that I or my authorized representative may request a copy of this authorization.
- I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative	Relationship, If Other Than Insured	Dated

Address:

Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalized fraud stated. ACE USA Accident &Health has adopted the fraud warning language prescribed by the District of Columbia as it's generalized fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications and enrollment forms.

District of Columbia Generic Warning:
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.

The following states have required us to use state specific language as follows:

California

"For your protection California law requires the following to appear on this form:

Any person who knowingly presents 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.

Colorado

"It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

Florida

WARNING: Any person who knowingly and with intent in injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New York

WARNING: Any person who knowingly and with 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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Oklahoma

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

New York:

Fraud Warning: "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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

Pennsylvania:

Fraud Warning: "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.

Oregon

WARNING: Any person who knowingly, and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud

Virginia

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may have violated state law.