Dear Policyholder:

Please complete and sign the attached claim form. Additionally, the following are items needed in order to process your Medical/Dental claim in the most efficient and expedient way possible.

SPECIAL NOTE FOR MEDICARE AND TRICARE POLICYHOLDERS: ***The policy you purchased is excess to any other health insurance you may have (medical or dental). For foreign medical treatment, if you are a Medicare policyholder with a supplemental carrier, we will require the disposition from the supplemental carrier, as most will pay some foreign expenses (even though Medicare will not). If you are a TriCare policyholder with a supplemental carrier, for foreign and domestic treatment, we will require the disposition from the supplemental carrier, as most will pay some foreign expenses (Our policy is primary to TriCare only). For both Medicare and TriCare policyholders, you must indicate on the claim form if you do not have a supplemental health plan and sign the enclosed affidavit of no insurance.***

What you should provide:

- A signed and completed "Patient's Authorization". Regulations under HIPAA (Health Information Portability and Accountability Act) were enacted nationwide by doctors' offices, hospitals and other health care providers. As a result, we must request that the patient or their authorized legal representative sign and complete the enclosed form in its entirety. Authorized legal representatives must include a copy of their designation as such. **Failure to provide this documentation may result in a delay of your claim**;

- The disposition of your claim with your primary insurance and supplemental insurance carriers;

- Proof of age for all travelers on the policy/certificate. If any travelers making a claim are minors, please provide the name and address of their parent or legal guardian;

- If you did not have any health insurance in effect at the time you incurred your expenses, please complete and sign the attached Affidavit of No Insurance;

- An itemization of all related bills, including dates, diagnosis, amounts, the names, addresses, telephone numbers of all doctors and hospitals where the patient was treated. Please include copies of the actual bills for consideration;

- Actual proof of payment for your trip, such as credit card statements or copies of the front and back of cancelled checks. Invoices will not be accepted as actual proof of payment;

- Proof of age for all parties making a claim. If any are minors, please provide the name and address of their parent or legal guardian. If there are multiple parties making a claim, please provide their relationship;

- ***EACH PARTY MAKING A CLAIM MUST SIGN THE COMPLETED CLAIM FORM.***

Thank you for this important information. Should you have any questions, please call us at (800) 541-3522.

ADDRESS
5251 Viewridge Court | San Diego, CA 92123
P.O. Box 939057, San Diego, CA 92193-9057

PHONE
TOLL FREE (800) 541-3522
FAX (877) 300-8670

WEB
www.CSATravelProtection.com
claims@csatravelprotection.com

AFFIDAVIT OF NO INSURANCE

I/we, _____ hereby declare under penalty of perjury that I/we do not have any other valid and collectible insurance or indemnity coverage that was in effect during the covered trip.

_____ _____
(Signature) (Date)

_____ _____
(Signature) (Date)

_____ _____
(Witness signature) (Date)

ADDRESS
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P.O. Box 939057, San Diego, CA 92193-9057

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claims@csatravelprotection.com

Patient Authorization Form

Name of Patient:_____ Date of Birth:_____
SS#:_____ Purpose of release: TRAVEL INSURANCE CLAIM

DOCTORS AND/OR MEDICAL FACILITIES AUTHORIZED TO RELEASE MY HEALTH INFORMATION:

Name	Address	Telephone	Fax	Dates Treated

You are authorized to release any health information that may have bearing on the request for benefits submitted in conjunction with the travel protection plan to: CSA Travel Protection and Insurance Services, its affiliates, underwriters, reinsurers, and any agent expressly acting on behalf of CSA Travel Protection and Insurance Services. Additionally, if there is potential fraudulent activity you release medical information related to the identification and prevention of the fraudulent activity to the underwriters, insurance support organizations, fraud information clearinghouses and designated service providers assisting in the processing of the claim.

Send to: CSA Travel Protection and Insurance Services
Attn: Claims Department, P.O. Box 939057, San Diego CA 92193-9057
FAX: 877-300-8670. Information to be released: Physician Dictation, Physical and/or Occupational Therapy Records, Office Notes, Lab Reports, Entire Record,
Other: _____

I UNDERSTAND THE FOLLOWING:

- If applicable, HIV/AIDS, genetic testing, abuse, drugs/alcohol and/or mental health records will be included in the health information that is released.
- I may revoke this authorization to the health information management department in writing. My revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless revoked, this authorization will expire in six months.
- I may inspect or copy the information to be used or disclosed, as provided in CFR164.524. Any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I am entitled to a copy of this authorization. A facsimile or photocopy can be treated as the original.
- THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.
- My treatment, payment, or enrollment may not be conditioned on signing this authorization. If I refuse to sign this authorization, benefits may not be paid under the travel protection plan if additional health information is needed to determine my eligibility for benefits.

Signature of patient or authorized person Date:

Relationship/Reason patient is unable to sign

MEDICAL EXPENSE CLAIM FORM

CSA TRAVELPROTECTION

IMPORTANT: BOTH SIDES OF THIS CLAIM FORM MUST BE COMPLETED IN FULL AND SIGNED. FAILURE TO DO SO MAY DELAY THE PROCESSING OF YOUR CLAIM.

SECTION 1: PERSONAL & TRAVEL INFORMATION

POLICY/REFERENCE #	TRAVEL DATES	BOOKING/RESERVATION #

NAME OF INSURED	DATE OF BIRTH	HOME PHONE	BUS/CELL PHONE	EMAIL ADDRESS

INSURED STREET ADDRESS	CITY	STATE	ZIP CODE

CO-INSURED/TRAVELING COMPANION(S)	DATE OF BIRTH	HOME PHONE	BUS/CELL PHONE	EMAIL ADDRESS

CO-INSURED/TRAVELING COMPANION(S) STREET ADDRESS	CITY	STATE	ZIP CODE

TRAVEL AGENT/RENTAL COMPANY	TRAVEL AGENT'S NAME	TELEPHONE	FAX	EMAIL ADDRESS

TRAVEL AGENT'S STREET ADDRESS	CITY	STATE	ZIP CODE

SECTION 2: DETAILS OF SICKNESS OR INJURY

NATURE OF SICKNESS OR INJURY	DATE FIRST TREATED

DATE SICKNESS FIRST BEGAN. IF INJURY, PLEASE LIST DATE AND TIME OF INCIDENT	IF INJURY, HOW AND WHEN DID ACCIDENT OCCUR?

WAS ACCIDENT REPORT COMPLETED FOR THIS INCIDENT? IF YES, PLEASE PROVIDE COPY	WERE YOU TREATED FOR THIS CONDITION PRIOR TO THE PURCHASE OF YOUR TRIP? IF YES, PLEASE LIST ALL DATES:

IF YES TO PRIOR QUESTION, PLEASE PROVIDE NAME, ADDRESS AND PHONE NUMBER OF TREATING PHYSICIAN

SECTION 3: MEDICAL FACILITIES (LIST HOSPITAL WHERE TREATED AND DOCTORS CONSULTED FOR THIS CONDITION)

NAME	ADDRESS	TELEPHONE	FAX	DATES
NAME	ADDRESS	TELEPHONE	FAX	DATES
NAME	ADDRESS	TELEPHONE	FAX	DATES

SECTION 4: OTHER INSURANCE INFORMATION

DO YOU HAVE OTHER HEALTH/MEDICAL INSURANCE? ☐ YES ☐ NO

HAVE YOU SUBMITTED A CLAIM TO YOUR PRIMARY/SUPPLEMENTAL INSURANCE CARRIER? ☐ YES ☐ NO (If not, please do so)

PRIMARY HEALTH OR DENTAL INSURANCE COMPANY	POLICY NUMBER	PHONE NUMBER

SUPPLEMENTAL HEALTH OR DENTAL INSURANCE COMPANY	POLICY NUMBER	PHONE NUMBER

PLEASE COMPLETE OTHER SIDE

SECTION 5: DESCRIPTION OF MEDICAL EXPENSES AND AMOUNT CLAIMED

PLEASE LIST ALL MEDICAL EXPENSES INCURRED AS A RESULT OF THIS SICKNESS/INJURY. ENCLOSE COPIES OF MEDICAL BILLS, REPORTS AND EXPLANATION OF BENEFITS FROM YOUR PRIMARY AND SUPPLEMENTAL HEALTH OR DENTAL INSURANCE COMPANY.

NAME OF DOCTOR/HOSPITAL	DATE TREATED	AMOUNT OF BILL	AMOUNT PAID BY OTHER INSURANCE	AMOUNT CLAIMED

FRAUD WARNINGS AND DISCLOSURES

Arizona: For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arkansas, New Mexico and Texas: 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.

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 any insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho and Indiana: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false or misleading information is guilty of a felony.

DC and Maine: 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.

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

Kentucky and Pennsylvania - 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.

Louisiana and 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.

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

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: 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.

New Jersey: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties.

New York: 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 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 violation.

Ohio: 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 is guilty of insurance fraud.

Oklahoma: 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.

Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to any insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

☐ By Checking this box, I/we agree that my/our typed signature(s) be accepted as my/our written signature(s) and attest that all of the statements in this document are true and complete to the best of my/our knowledge, and I/we authorize CSA Travel Protection and Insurance Services to release and share claim information including that which may be used in the identification and prevention of potential fraudulent activity to Stonebridge Casualty Insurance Company, United States Fire Insurance Company, insurance support organizations, fraud information clearinghouses, designated service providers and business associates assisting in the processing of the claim.

INSURED SIGNATURE _____ **DATE** _____