

PROOF OF LOSS

Co-ordinated Benefit Plans, Inc.
P.O. Box 26222
Tampa, FL 33623-6222
(866) 282-6524 / Fax (727) 799-9093

Insurance Carrier: Virginia Surety Company, Inc.
Program Reference # HTPIO09269
Program Name: Visit Plans
ID Number: _____

PERSONAL LIABILITY CLAIM FORM

Instructions:

- 1.) This form is to be used when filing a claim for Personal Liability and must be completed by the Insured in full.
- 2.) This form must be signed and dated in all applicable sections. In some cases, two signatures are required (minor dependent).
- 3.) **Please mail the completed form to the above address, along with proof of coverage and any reports pertaining to this incident.**

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract. Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

1.) Coverage Effective Date ___/___/___ 2.) Coverage Termination Date ___/___/___ 3.) E-mail address: _____

4.) Name of Insured: _____ 5.) Date of Birth ___/___/___ 6.) Sex: ___ Male ___ Female

7.) Name of Claimant: _____ 8.) Date of Birth ___/___/___ 9.) Sex: ___ Male ___ Female

10.) Current Residence Address: _____

11.) Daytime Phone Number: (_____) _____

12.) Date of Arrival in U.S. or Host Country: ___/___/___ 13.) Date scheduled to return to Home Country: ___/___/___

14.) Permanent Address (In Home Country): _____

15.) Name of School: _____ 16.) Are you currently still enrolled in this school? Yes ___ No ___

17.) Date of Incident: ___/___/___ 18.) Location of Incident: _____ 19.) Police/Security Notified: Yes ___ No ___

20.) Description of Incident: _____

21.) Extent of Damage/Injury: _____

22.) Name(s) and Address(es) of Witness(es): _____

23.) Person to contact for additional information: _____ 24.) Phone Number (_____) _____

I hereby certify that the above information is true and correct to the best of my knowledge and belief.

Signature

Date

Signature of Claimant or Parent, If Claimant is a Minor

Date