

# PROOF OF LOSS



Co-ordinated Benefit Plans, Inc.  
P.O. Box 26222  
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Insurance Carrier: Virginia Surety Company, Inc.  
Program Reference # HTPIO09269  
Program Name: Visit Plans  
ID Number: \_\_\_\_\_

## ACCIDENT, ILLNESS OR PRESCRIPTION CLAIM FORM

### Instructions:

- 1.) This form is to be used when filing a claim for reimbursement of Medical Expenses and must be completed by the Insured in full, for each diagnosis.
- 2.) Fully itemized bills including: Claimant's Name and Nature of Illness/Injury must be included with this claim form, if applicable.
- 3.) **Copies of your Passport and either your I-20 or DS-2019 Visa or Form I-94 MUST be submitted with this claim form.**
- 4.) This form must be signed and dated in all applicable sections. In some cases, two signatures are required (minor dependent).
- 5.) This form and all attached bills must be submitted to the address indicated above.

**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.) Date of Arrival in U.S. or Host Country: \_\_\_/\_\_\_/\_\_\_
- 12.) Daytime Phone Number: (\_\_\_\_\_) \_\_\_\_\_
- 13.) Permanent Address (In Home Country): \_\_\_\_\_
- 14.) Date scheduled to return to Home Country: \_\_\_/\_\_\_/\_\_\_
- 15.) Name of School: \_\_\_\_\_
- 16.) Are you currently still enrolled in this school? Yes \_\_\_ No \_\_\_
- 17.) If Accident, provide details, i.e., how when and where accident occurred: \_\_\_\_\_  
\_\_\_\_\_
- 18.) If Illness, advise when and where symptoms first occurred and nature of illness: \_\_\_\_\_  
\_\_\_\_\_
- 19.) Name and address of Consulting Physicians: \_\_\_\_\_  
\_\_\_\_\_
- 20.) Have you ever been treated for this Illness before? Yes \_\_\_ No \_\_\_ If Yes, when? \_\_\_\_\_
- 21.) Provide Name and Address of your Regular Physician in your Home Country: \_\_\_\_\_  
\_\_\_\_\_
- 22.) Please advise names of any prescription medications you are presently taking: \_\_\_\_\_  
\_\_\_\_\_
- 23.) Indicate other Health Insurance coverage, include name, address, policy number and certificate number of Insurer: \_\_\_\_\_  
\_\_\_\_\_

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 Claim Administrator named above or its representatives, any and all information with respect to any injury or illness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, illness 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 group policyholder, employer or benefit plan administrators to provide the Claim Administrator 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 understand that I or my authorized representative may request a copy of this authorization.

\_\_\_\_\_  
Signature of Claimant or Parent, If Claimant is a Minor

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date