iTravelInsured Medical Expense/Emergency Medical Evacuation Repatriation/Return of Remains Claim Form

Please print legibly and complete ALL SECTIONS (front and back) of this application. Send this form by secure methods only.
Address: International Medical Group, Travel Claims, PO Box 241853, Apple Valley, MN 55124
Call: 1.866.243.7524 or 1.317.655.9798; **Fax:** +1.317.927.6882
Email: iTravelClaims@imglobal.com
www.imglobal.com

To report a loss, return the required documentation along with your original, signed claim form to IMG® Claims. A delay in the processing of the claim will occur if acceptable proof of loss or an incomplete claim form is submitted. Proof of loss must be submitted within 90 days of the date of loss. IMG reserves the right to obtain further information needed to determine eligibility for benefits and the proper payee.

MEDICAL EXPENSES - REQUIRED DOCUMENTATION

- ☐ Doctor, Hospital, Ambulance, and/or Pharmacy
  Original receipts/itemized billings for any out-of-pocket medical expenses incurred
- ☐ Proof of Payment
  Credit card statements, cancelled checks, wire transfer receipts, or payment receipts for payments made to the service provider
- ☐ Medical Records
  Copy of all medical documentation for services rendered to the insured person
- ☐ Medical Authorization
  An authorization to release information to IMG® must be provided. A delay in the processing of the claim will occur if this is not provided
- ☐ Official Reports
  A copy of the death certificate, police report, autopsy, coroner, toxicology, and findings from any investigating entity is needed

INSURED INFORMATION

Insured's Name *(Last, First, Middle)*:	Policy Number:
Mailing Address:	
Email Address:	
Cell Phone Number *(With area code)*:	

Please note: by providing an email address and cell phone number on this form, you agree to electronic communications (including emails and SMS) about any claims that you have submitted.

PART 1. GENERAL INFORMATION

1. Full Name of Claimant: *(If additional travelers, please attach complete a separate claim form)*				Date of Birth: ___/___/___ *(MM/DD/YYYY)*
Policy Number:		Relationship to Insured:		
Name of Travel Supplier *(e.g. cruise line, airline, etc.)*:				
Travel Agency's Full Name:	Travel Agent's Name:			Telephone Number *(With area code)*:
Travel Agency's Mailing Address:				Email Address:
Initial Deposit Date Paid for Trip: ___/___/___ *(MM/DD/YYYY)*	Final Payment Date: ___/___/___ *(MM/DD/YYYY)*	Departure Date: ___/___/___ *(MM/DD/YYYY)*	Schedule Return Date: ___/___/___ *(MM/DD/YYYY)*	Actual Return Date: ___/___/___ *(MM/DD/YYYY)*
Departure City:		Destination (City, Country, or State):		
Please check the box for benefits requested: ☐ Medical/Dental Expenses ☐ Evacuation/Repatriation/Return of Remains Expenses				

PART 2. EXPLANATION OF ACCIDENT, SICKNESS, OR INJURY

Describe in detail what occurred:

Please list the expenses related to the loss. Attach additional sheets if necessary:

Insured Name	Medical Provider	Date of Service *(MM/DD/YYYY)*	Charge Amount *(List currency)*
		___/___/___	
		___/___/___	
		___/___/___	
		___/___/___	
		___/___/___	
		Less payments by other coverage:	
		Total amount of claim:	

Reminder: *Any insurance is in excess of other insurance or indemnity. If at the time of the loss there is any other insurance or indemnity, the contract only offers reimbursement for the excess of the loss amount above the amount of other insurance or indemnity. Insureds must first file a claim with the other carrier and forward a copy of that carrier's decision.*

PART 3. MEDICAL INFORMATION

Patient's Name:	Date Symptoms First Noticed: ___/___/___ *(MM/DD/YYYY)*
Nature of Illness:	Date of First Consultation: ___/___/___ *(MM/DD/YYYY)*
Describe onset, diagnosis, and treatment:	
For injury, describe injury:	Date of First Consultation: ___/___/___ *(MM/DD/YYYY)*
How and where did the accident occur:	
If hospitalized, hospital name, website, and address:	Dates of Confinement: ___/___/___ *(MM/DD/YYYY)*
	From: To:
Name and address of treating physician:	Telephone Number *(With area code)*:
	Fax Number *(With area code)*:

PART 4. OTHER COVERAGE

Do you have any other insurance or coverage related to the loss *(e.g. Domestic Health Insurance, Travel, Homeowners, etc.)*?	☐ Yes ☐ No
Do you have any other travel insurance coverage?	☐ Yes ☐ No
Did you report the loss to any other insurance company?	☐ Yes ☐ No

If Yes, which company:

Name of Company:	Policy/Certificate Number:	Telephone Number *(With area code)*:	Website:
1. _____	_____	_____	_____
Address: _____			
_____			
2. _____	_____	_____	_____
Address: _____			
_____			
3. _____	_____	_____	_____
Address: _____			
_____			
(Please attach a separate sheet if necessary)			

CLAIM FORM FRAUD STATEMENT
FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

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.

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 and KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

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.

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. 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.

FLORIDA: WARNING: Any person who knowingly and with intent to 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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

MARYLAND: 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.

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 any false or misleading information is subject to criminal and civil penalties.

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.

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

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 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.

AUTHORIZATION

The undersigned authorizes any health plan, healthcare provider, healthcare professional, MIB, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency, employer, benefit plan, or any other organization or person that has provided care, advice, diagnosis, payment, treatment, or services to the insured or on the insured's behalf, has any records or knowledge of the insured's health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the insured, and any non-medical information about the insured, to disclose the insured's entire medical record, file, history, medications, and any other information concerning the insured and to give any and all such information to the insured's agent of record and authorized representatives of the insurer, IMG, and their affiliates, and subsidiaries.

This information will be used to evaluate claims for benefits. Individuals have the right to refuse to sign the authorization without negative consequences to treatment or plan enrollment, except IMG will not be able to administer claims, determine benefit eligibility, or issue payments. The authorization is valid for the term of the insurance contract or plan under which a claim has been submitted. The undersigned understands that the insured has the right to receive a copy of this authorization upon request and revoke the authorization at any time in a written communication to IMG. A copy of this shall be as valid as the original. The undersigned acknowledges and understands there is the potential for the information to be subject to redisclosure by the recipient and to no longer be protected by applicable privacy and confidentiality laws.

The undersigned represents and warrants information or documents provided to IMG by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees:

1) Any insurance coverage or benefit is contingent upon any statement made to IMG as being complete and correct
2) Benefits under any contract will be paid only if IMG decides the applicant is entitled to them

Signature of Insured/Claimant: X _____ Date: ___/___/___ *(MM/DD/YYYY)*