

Mailing Address: 1 High Ridge Park, Stamford, CT 06905 | **E-mail:** claimhelp@mycisi.com | **Fax:** (203) 399-5596
For claim submission questions, call (203) 399- 5130 or e-mail claimhelp@mycisi.com

INSTRUCTIONS:

1. Fully complete and sign the medical claim form for each occurrence, indicating whether the Doctor/Hospital has been paid.
2. Attach itemized bills for all amounts being claimed. *We recommend you provide us with a copy and keep the originals for yourself.
3. Approved reimbursements will be paid to the provider of the service unless otherwise indicated.
4. Submit claim form and attachments via mail, e-mail, or by fax (provided above).

See next page for state specific disclaimers, claimant cooperation provision and additional claim submission instructions.

***** IMPORTANT: If your claim pertains to an Accident, SECTION 2 MUST be completed. If your claim pertains to a Sickness/Illness, SECTION 3 MUST be completed. Failure to complete one of these sections (whichever section pertains to your claim), will cause a delay as we will request for you to complete this form again to include this necessary information in order to process your claim. For claims related to one of the Travel Assistance Benefits, see Section 5.**

SECTION 1: NAME AND CONTACT INFORMATION OF THE INSURED

Name of the Insured: _____ Date of Birth: _____ / _____ / _____
(month/day/year)

*Please indicate which is your home address: U.S. Address Address Abroad

U.S. Address: _____
street address apt/unit # city state zip code

Address Abroad: _____

E-mail Address: _____ Phone Number: _____

SECTION 2: IF IN AN ACCIDENT***

Date of Accident: _____ / _____ / _____ Place of Accident: _____ Date of Doctor/Hospital Visit: _____ / _____ / _____

Description/Details of Injury (attach additional notes if necessary): _____

SECTION 3: IF SICKNESS/ILLNESS***

Description of Sickness/Illness (attach additional notes if necessary) : _____

Onset Date of Symptoms: _____ / _____ / _____ Date of Doctor/ Hospital Visit: _____ / _____ / _____

Have you had this Sickness/Illness before? YES NO If yes**** **FOR BAGGAGE** .dnyoo58 ()JTJ ET q 0 0 612 792 re W n BT 0.149 G 0.214 w /C2_0 1 Tf 0 Tc 0 Tw 2

..EMERGENCYMEDICAL REUNION ..CHAPERONE REPLACEMENT

Please provide us with the relevant details of your incident below or the details and value of your losses. You may attach an additional page if ()8 .1 (d)h th a6(age)5 0ten

For residents of Pennsylvania: Any person who knowingly and with the 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.

For claimants not residing in Alabama, Arkansas, California, Color