Medical Expense Claim Form

While on my trip, I had expenses for medically necessary treatment due to an injury or sickness.

Step 1 – Provide Documentation (provide all)

Provide the following required documentation:

- ☐ Provide copies or photos of your itinerary and paid invoice.
- ☐ Provide copies or photos of itemized bills or similar documentation from your healthcare providers.
- ☐ Provide copies or photos of medical reports and/or physician statements to support your claim.
- ☐ Provide copies or photos of the payment and/or explanation of benefits from your primary or supplemental insurance carrier, if applicable.
- ☐ Provide proof of when your property was returned to you (if applicable).
- ☐ Provide copies or photos of any documentation that supports the reason for your claim.

Step 2 - Submit All Pages of this Claim Form

Completed claim form and documentation can be submitted by either:

- ☐ **Scan/Upload:**
- ☐ **Mail to:**
  Health Special Risk, Inc.
  P.O. Box 250649
  Plano, TX 75025-0649
- ☐ **Email to:** GallagherZurich@hsri.com
- ☐ **Fax to:** 972-512-5818

If you have questions about your claim, our customer service team is available by phone at 866-409-5734, or by email at GallagherZurich@hsri.com

About Me

Name of the person completing form (First and Last) | **Confirmation/Policy Number**

Mailing address ☐ *Check if this is a change of address.* | **City** | **State** | **Postal code**

Mobile phone | **Other phone** | **Email address**

Full names of all persons claiming | **Relationship to person completing form**

Name of agency/company you purchased your travel insurance from | **Date initial deposit paid for trip** (mm/dd/yyyy)

About What Happened

Please provide a detailed description

Medical Expense Claim Form

Note – Benefits under any coverage will not be paid for expenses reimbursed or services provided by any other source. Benefits cannot be duplicated under this protection plan and claims will be adjusted in accordance with the terms of the policy.

About the Medical Expenses Incurred

Name of Medical Service Provider / Doctor	Date of Service *(mm/dd/yyyy)*	Hospitalized *(Yes / No)*	Prescribed Medication *(Yes / No)*	Amount on Invoice *(USD)*	Did You Pay this Invoice? *(Yes / No)*	Amount Paid by Other Insurance *(USD)*	Amount Requested for Reimbursement *(USD)*
		Choose an item.	Choose an item.		Choose an item.		
		Choose an item.	Choose an item.		Choose an item.		
		Choose an item.	Choose an item.		Choose an item.		
		Choose an item.	Choose an item.		Choose an item.		
		Choose an item.	Choose an item.		Choose an item.		
Total Amount Requested for Reimbursement in USD							

If you have more expenses, please provide a breakdown on an additional sheet using above format.

Physician Name **Phone**

Mailing Address **City** **State** **Postal code** **Fax**

About Other Coverage

Do you have any other insurance coverage? (e.g. Medicare, Blue Cross, workplace/group insurance, credit cards, etc.) ☐ YES ☐ NO **If YES, complete the following:**

1. Name of Insurance Company **Policy Number** **Phone**

Address of Insurance Company

2. Name of Insurance Company **Policy Number** **Phone**

Address of Insurance Company

Was your medical emergency caused by an accident? ☐ YES ☐ NO **If YES, do you believe a third party was responsible?** ☐ YES ☐ NO **If YES, complete the following:**

Name of Third Party **Phone**

Third Party Mailing Address **City** **State** **Postal code**

If the claim has been submitted to another insurance company for these expenses, please provide:

Name of Insurance Company **Claim Number**

I DECLARE THE ABOVE INFORMATION IS TRUE, COMPLETE AND CORRECT.

I authorize any other insurance company, under which I have coverage to disclose information as may be necessary with respect of my claim with Zurich American Insurance Company directly. I also authorize Zurich American Insurance Company to disclose to any other insurance company, under which I have coverage, any and all information as may be necessary with respect to my claim.

Signature or typed name of the person completing this form **Date** (mm/dd/yyyy)

☐ The person completing this form understands **checking this agreement box** and **typing your name** in the signature box above constitutes an electronic signature and consent to file this claim electronically. Electronic signatures are legal and enforceable in the same fashion as a traditional signature.

Claim Form Fraud Requirements

Mandatory – Please read and sign below.

All states other than those listed:
For your protection state 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 or benefit with the intent to defraud or deceive any insurer is guilty of a crime and may be subject to criminal and civil penalties and denial of insurance benefits.

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

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 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
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.

New Jersey
Any person who knowingly files a statement of claim containing any 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 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.

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.

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.

Washington
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.

Puerto Rico
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

I ACKNOWLEDGE that I have read the fraud statement that applies to my state of residence. If my state of residence is not listed, I acknowledge that I have read the "All states other than those listed".

Signature or typed name of the person completing this form **Date** (mm/dd/yyyy)

☐ The person completing this form understands **checking this agreement box** and **typing your name** in the signature box above constitutes an electronic signature and consent to file this claim electronically. Electronic signatures are legal and enforceable in the same fashion as a traditional signature.