

Please detach the below insurance card and keep it always with you



CLAIM FORM
MEDICAL / DENTAL
DAMAGED / STOLEN PROPERTY (Back)

SECTION 1. PLEASE PRINT OR TYPE CLEARLY. This section must be filled out completely for all claims.

First and last name of Insured (list all names you are known by)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Home Country Address		Phone #	
Host Country Address		Phone #	
Email address			
Home Country Departure Date	Home Country Return Date	Has previous form been submitted for this claim ? <input type="checkbox"/> Yes - Date <input type="checkbox"/> No	
Date of sickness / accident	Were you in a motor vehicle accident ? <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of driver and address	Have you had any previous treatment for this condition ? <input type="checkbox"/> No <input type="checkbox"/> Yes, if so when ?	month year
Date first saw physician	Are you cured ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Benefits should be paid to : <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital <input type="checkbox"/> Camp / Exch. Org <input type="checkbox"/> Insured <input type="checkbox"/> Host family <input type="checkbox"/> Other (specify)	
Are you eligible for a National Medical System in your Home country ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does any other Insurance company cover this illness or injury ? <input type="checkbox"/> No <input type="checkbox"/> Yes, Compagny Name, address & policy #	Should you wish a bank transfer, please make sure to provide your complete bank details (bank name, bank address, account n , IBAN and SWIFT codes).	
Describe your illness or injury. If injury, how did it happen ?			
.....			
.....			

SECTION 2 : TO BE COMPLETED BY CLAIMANT (Participant). CLAIM CANNOT BE PROCESSED WITHOUT INSURED SIGNATURE
MEDICAL RELEASE FORM
 I HEREBY CERTIFY that the above statements are true and correct to the best of my knowledge, and further I AUTHORIZE THE INSURANCE COMPAGNY or any party the Company authorizes to obtain, or release any information acquired in the course of my examination or treatment.
 I CERTIFY that I will make no claims on lost or damaged property after reimbursement has been paid, should the property later be recovered, and that I will notify the Company immediately should I take possession of said property.
 Sign here
Participant *Date and Place*

SECTION 3 : TO BE COMPLETED BY ATTENDING PHYSICIAN

Diagnosis :	Has patient ever had same or similar symptoms ? <input type="checkbox"/> No <input type="checkbox"/> Yes, if so when & where
Is it a congenital condition ? <input type="checkbox"/> No <input type="checkbox"/> Yes.....	
<i>Signature of Physician or Supplier</i>	

SECTION 4 : TO BE FILLED OUT BY THE PARTICIPANT. Please itemize all the medical charges & expenses as is applicable.
Attach all ORIGINAL (not photocopies) bill and receipts.

DATE OF SERVICE	NAME OF MEDICAL SERVICE PROVIDER/PHARMACIES	CHARGES
.....
.....
.....
TOTAL MEDICAL AND/OR MEDICATION BILL CLAIM AMOUNT

PROPERTY CLAIM ONLY
PLEASE FILL OUT SECTION # 1, 2, 5, & 6

SECTION 5 : COMPLETE FOR PERSONAL PROPERTY (DAMAGED/STOLEN ARTICLES)

What kind of damage/loss ?	When & where did the damage/loss occur ? (yr/mo/day)	Become noticed (yr/mo/day)
Where were you when damage/loss was noticed ?	Has the damage/loss been reported (attach report) <input type="checkbox"/> Police <input type="checkbox"/> Transport Co. <input type="checkbox"/> Area Rep. <input type="checkbox"/> School/Hotel	
Where were articles kept when damage/loss occurred ?	Was the room locked ? <input type="checkbox"/> No <input type="checkbox"/> Yes; Where was the key	
Was the storage place (suitcase, locker, drawer, etc...) locked ? <input type="checkbox"/> No <input type="checkbox"/> Yes; Where was the key ?	What other step was taken to protect items ?	
Describe in detail the circumstances of damage/loss (list damaged/stolen property below, section 6) :		
.....		
.....		
.....		
(Attach separate sheet if necessary)		
Does any other insurance cover this damage/loss ?		
<input type="checkbox"/> No <input type="checkbox"/> Yes; Company Name, Address & Policy no.		

SECTION 6 : COMPLETE FOR ALL CLAIMS

☞ Property damage/loss : List below all stolen/damaged property. Include original purchase price or repair cost. Attach original bills and receipt
Replacement invoices will NOT be considered proof of property or proof of value.

Describe property in detail	To be paid to : (attach list if needed)	For Property Claim Only		Amount of Claim
		Purchase Amount or Repair Cost	Date of Purchase	
.....				
.....				
.....				
.....				
.....				
.....				
.....				
(Attach separate sheet if necessary)				

Compensation to be paid to <input type="checkbox"/> Insured	<input type="checkbox"/> Host Family
<input type="checkbox"/> Someone Else (Full name, Address and reason)	<input type="checkbox"/> Camp (Full name, Address and reason)