

Make sure to complete this form as thoroughly as possible. If this form is not complete it will increase the processing time to get the claim paid. If you have any questions feel free to contact your local AYUSA staff person or AYUSA HQ. All sections highlighted below must be complete.



**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	Is there any pending medical invoice we should receive ? <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 cured ? <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 ?				

All pre-existing conditions are not covered by AVI insurance

If you do not know the answer to this question call your medical provider or the insurance company. They will be able to give you more information on what other documents you may need to send in to complete this form.

Be sure to complete this section thoroughly.

SECTION 2 : TO BE COMPLETED BY CLAIMANT (Participant). CLAIM CANNOT BE PROCESSED WITHOUT INSURED SIGNATURE

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

Be sure to sign and date Section 2

SECTION 3 : TO BE COMPLETED BY ATTENDING PHYSICIAN

Diagnosis :

Has patient ever had same or similar symptoms ? No Yes, if so when & where

Is it a congenital condition ? No Yes.....

Make sure to have this section completed by your medical provider. *Signature of Physician or Supplier*

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		

Be sure to make photocopies of all your receipts and save them in a safe place.