ZURICH TRAVEL INSURANCE
PROOF OF COVERED LOSS - TRAVEL MEDICAL INSURANCE CLAIM FORM

1. CLAIM INSTRUCTIONS

- V Verify that all information is accurate and make changes where required.
- Complete this form in full and attach all documents as requested.
- Sign and date completed form and return package to:
  Administrative Concepts, Inc.
  P.O Box 4000
  Collegeville, PA 19426
- Email: claims@visit-aci.com

For Claims Inquiries, please contact: (888) 293-9229, then press "2"

Failure to complete the claim form and attached requested documents will delay the processing of your claim.

Please attach the following documents:

- Original itemized receipts for all bills and invoices;
- Proof of payment by you and by any other benefit plan;
- Medical records including complete diagnosis by the attending physician or documentation by the hospital, which must support that the treatment was medically necessary;
- Proof of the accident if you are submitting a claim for dental expenses resulting from an accident;
- Proof of travel (including departure date and return date); and
- Your Historical Medical Records (if we determine applicable).

Please keep a copy of all the submitted correspondence for your records.

WHAT TO EXPECT DURING THE CLAIMS PROCESS

IF YOU HAVE CONTACTED THE EMERGENCY ASSISTANCE CENTER, WE WILL HAVE ARRANGED TO HAVE ALL BILLS SENT DIRECTLY TO ZURICH TRAVEL ASSIST AND ONCE ELIGIBILITY AND PAYABILITY ARE DETERMINED, THE APPROVED PAYMENTS WILL BE SENT DIRECTLY TO THE FACILITIES AND/OR HEALTH PROVIDERS.

IN ORDER TO EXPEDITE YOUR CLAIM, PLEASE RETURN THE COMPLETED CLAIM FORM AND ALL SUPPORTING DOCUMENTS AS SOON AS POSSIBLE AND KEEP A COPY FOR YOUR RECORDS.

2. INSURED INFORMATION

Name:_____ Date:_____

Address:_____ Home Phone:_____

City:_____ State:_____ Mobile Phone:_____

Zip Code:_____ Country:_____ Email:_____

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3. INSURED DETAILS

Your Zurich Travel Policy Number:		Expiration Date (MM/DD/YYYY):
Name of Ill or Injured Person:	Relationship To Insured:	Date of Birth (MM/DD/YYYY):
Social Security Number:		
Departure Date (MM/DD/YYYY):	Return Date (MM/DD/YYYY):	

4. CLAIM DETAILS

Nature Of Sickness Or Injury:	Country Where Incident Occurred:	Date of Incident (MM/DD/YYYY):
Describe How Incident Occurred:		
Have You Paid Any Invoices? ☐ Yes ☐ No	If Yes, Provide Amount Paid: $	Currency:
NAME, ADDRESS AND TELEPHONE NUMBER OF ALL PHYSICIANS AND SPECIALISTS THAT THE CLAIMANT HAS SEEN PRIOR TO THE DEPATURE DATE		
Name And Specialty:	Address:	Telephone Number:
Name And Specialty:	Address:	Telephone Number:

5. OTHER INSURANCE COVERAGE (IF THE INSURED IS A CHILD, THIS SECTION IS APPLICABLE TO THE PARENT OF LEGAL GUARDIAN)

THIS INSURANCE PAYS ELIGIBLE EXPENSES IN EXCESS OF THOSE COVERED BY ANY OTHER INSURANCE. THEREFORE, IF AT THE TIME OF LOSS, YOU HAVE SIMILAR COVERAGE WITH ANOTHER PROVIDER (I.E. CREDIT CARD, TRAVEL INSURER, EMPLOYMENT GROUP HEALTH PLAN, PRIVATE OF PROVINCIAL AUTO PLAN, ETC.)

	Group Policy #	Member ID	Name of Insurance Co.
Your Employer:			
Your Spouse's Employer:			
Do you have Medicare/Medicaid? ☐ Yes ☐ No	If Yes, please provide policy details:		
Do you have any other insurance which may apply? ☐ Yes ☐ No	If Yes, please provide policy details:		

FOR COMPLETE COVERAGE INFORMATION, PLEASE REFER TO YOUR POLICY GUIDE AND CERTIFICATE OF INSURANCE.
BENEFITS ARE UNDERWRITTEN BY ZURICH AMERICAN INSURANCE COMPANY.

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5. OTHER INSURANCE COVERAGE (CONTINUED)		
CREDIT CARDS		
Do You Have Supplementary Credit Card Insurance Coverage For Travel? ☐ Yes ☐ No		
Issuing Bank:		First Six Digits Of Card:
Is This Claim The Result Of A Motor Vehicle Collision? If Yes, Complete The Following:		
	Name Of Company	Policy Number
Your Auto Insurance		
Other Party's Insurance		

6. CERTIFICATION AND AUTHORIZATION
I/WE AUTHORIZE ANY LICENSED PHYSICIAN, MEDICAL PRACTITIONER, HOSPITAL, CLINIC, OTHER MEDICAL FACILITY OR PROVIDER OF HEALTH CARE, INSURER OR REINSURER, PROVINCIAL HEALTH INSURANCE PLAN AND EMPLOYER(S) TO PROVIDE ZURICH TRAVEL ASSIST, AND ITS REPRESENTATIVES EMPLOYED TO ASSIST IN THE ADMINISTRATION OF THIS CLAIM, ANY INFORMATION, INCLUDING PERSONAL INFORMATION, DATA OR RECORDS THAT ARE IN THEIR POSSESSION/KNOWLEDGE REGARDING MY MEDICAL HISTORY AND TREATMENT. I/WE AUTHORIZE ZURICH TRAVEL ASSIST, TO COORDINATE THE PAYMENT OF BENEFITS WITH ANY OTHER INSURANCE CARRIERS WHICH ALSO MAY HAVE A LIABILITY FOR THIS CLAIM. I/WE IRREVOCABLY DIRECT ZURICH TRAVEL ASSIST, TO MAKE ANY PAYMENTS, RECEIVE PAYMENTS AND SETTLE WITH OTHER CARRIERS ON MY BEHALF.

_____ _____

Signature Date