POINT COMFORT TRAVEL

Claimant's Statement and Authorization (CSA)

Notice to Insured Persons: Your insurance requires submission of valid Proof of Claim within a limited time frame as indicated in your Certificate. This document is an essential part of Proof of Claim. Failure to submit an accurate, legible, completed and signed Claimant's Statement and Authorization together with all required attachments within the specified time frame will result in processing delays and may result in denial of coverage for failure to submit Proof of Claim.

PART A: Claimant Information

Claimant (Patient) Full Name: (as it appears on ID card)	Date of Birth: (mm/dd/yyyy)	Gender: ☐ Male ☐ Female
ID Number: (found on ID card)	Passport/Visa Number:	
Home Country Address: (Street, City, State/Province, ZIP/Postal Code, Country)		
Current Address: (if different)		
Email Address:	Telephone Number:	
Citizenship:	Countries Visited During Trip:	

Are you a full-time student or scholar?

☐ Yes ☐ No

If Yes, attach **Student/Scholar Verification form**.

Are you employed:

☐ Yes ☐ No

If yes, name and address of employer: (Street, City, State/Province, ZIP/Postal Code, Country)

Do you or any family members have other coverage (medical, indemnity, liability or other)?

☐ Yes ☐ No

If yes, provide name of Company:

Address of Company: (Street, City, State/Province, ZIP/Postal Code, Country)

Name of Policyholder: Policy Number:

FORM CONTINUES ON NEXT PAGE ▶

PART B: Claim Information (If more space is needed, attach additional sheets.)

1. Where were you located when the condition began?

2. When did the first symptoms of the condition begin? State the exact date and time if possible.

   Date: (mm/dd/yyyy) Time:

   If due to an accident, attach **General Accident Questionnaire**.

3. Describe fully all symptoms and describe the condition in detail from the beginning:

   ☐ See attached

4. A. Have you ever had or been treated for the same kind of illness or injury?

   ☐ Yes ☐ No

   B. If yes, please provide the name, address and telephone number of physician:

5. Name, address and telephone number of family or personal physician, even if not consulted:

6. A. Prior to the onset of this condition, were you taking any prescription medications?

   ☐ Yes ☐ No

   B. If yes, list all prescriptions and dosage:

   ☐ See attached

7. **What ailments, diseases, illnesses, conditions or injuries have you had during the last five years? Provide name and/or description of each condition, dates involved and the name, address and telephone numbers for physicians:**

   ☐ See attached

8. A. Is this the result of an accident or illness related to your employment?

   ☐ Yes ☐ No

   B. If yes, are you applying for Workers Compensation benefits?

   ☐ Yes ☐ No

9. Is this condition the result of a motor vehicle accident or another person's actions?

   ☐ Yes ☐ No

   If yes, attach **General Accident Questionnaire.**

10. Is this condition the result of participation in athletic activities or sports?

    ☐ Yes ☐ No

    If yes, attach **General Accident Questionnaire** and **Sports Questionnaire.**

FORM CONTINUES ON NEXT PAGE ▶

PART C. Complete for all treatment received outside the United States

1. Location of Treatment: (Street, City, State/Province, ZIP/Postal Code, Country)

Date of Service: (mm/dd/yyyy)	**Provider:**	**Type of Service/Name of Drug Provided:**	**Amount Charged:** (Attach Bill, Invoice, and Paid Receipt)	**Currency:**

FORM CONTINUES ON NEXT PAGE ▶

PART D: Verification

I verify that all information contained in this form is true, correct and complete to the best of my knowledge.

I authorize any health plan, health care provider, health care professional, MIB, federal, state or local government agency, insurance or reinsurance company, consumer reporting agency, employer, educational institution or any other organization or person that has any records of knowledge of my health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to disclose my entire medical record, file, history, medications and any other information concerning me and to give any and all such information to PCU or their authorized representatives, affiliates and subsidiaries.

I understand that I have the right to refuse to sign this Authorization without negative consequences as to treatment or plan enrollment, except PCU will not be able to administer claims, determine benefit eligibility or issue payments.

This Authorization is valid for the term of the insurance plan under which a claim has been submitted.

I understand that I have the right to receive a copy of this Authorization upon request and to revoke this Authorization at any time in written communication to PCU.

A copy of this Authorization shall be as valid as the original.

INSURED

Printed Name of Insured:	**Date: (mm/dd/yyyy)**

Signature of Insured:

Authorization: I authorize payment of any benefits for eligible expenses to the provider or other supplier of services which is entitled to payment of the attached bills.

If this form is signed by someone other than the patient or parent, such as a personal representative, legal representative or guardian on behalf of the patient, submit the following: a copy of a healthcare representative form, power of attorney, a court order or other documentation snowing custody or other legal documentation showing the authority to act on the patient's behalf.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.