How to **Submit a Claim**

All claims must be reported within ninety (90) days of occurrence.

1. Gather all your claim documentation.
   You are responsible for any fees charged for issuing supporting documentation that may be required.
2. Complete and sign the claim form.
   The claim form must be completed by the insured or by a parent or legal guardian if the insured is a minor.
3. Mail all documentation to 5301 Blue Lagoon Drive. Suite 580. Miami, FL 33126 USA.
   You can also submit your claim online through the MyVUMI portal.

Claim **Checklist**

- ☐ The fully completed claim form, signed and dated.
  Incomplete claim forms will be returned to you, and this will delay the processing of your claim submission.
- ☐ All invoices and payment receipts.
- ☐ For annual trip plans: proof of departure from the country of residence.
  For example: boarding pass; plane ticket; copy of stamped passport; if driving, credit or debit card statement showing purchases before leaving state/province and after arriving at destination.
- ☐ A report from the treating physician, hospital, clinic or emergency room indicating the service date and diagnosis.
- ☐ A copy of all prescriptions for medication.
- ☐ A copy of a police report in case of an accident.
- ☐ A copy of all documents for your records.

CLAIM FORM BEGINS ON THE NEXT PAGE

SUBMIT COMPLETED FORMS AND SUPPORTING DOCUMENTATION TO:

VUMI
5301 Blue Lagoon Drive. Suite 580.
Miami, FL 33126 USA

TO CHECK CLAIM STATUS, CONTACT:

Toll-Free (U.S. and Canada): **1.833.226.7753**
Collect (Worldwide): **+1.416.645.1187**
Email: **travelclaims@vumigroup.com**

Section I. **Information About the Insured**

1. Policy number: | 2. Last name: | 3. First name: | 4. M.I.:

5. Date of birth: M M / D D / Y Y Y Y | 6. Gender: ○ Male ○ Female | 7. Phone number: | 8. Fax number: | 9. Email address:

10. Address: | 11. City: | 12. State: | 13. ZIP code: | 14. Country:

Section II. **Information About the Trip**

1. City and country of destination:

2. Travel period:
From: M M / D D / Y Y Y Y To: M M / D D / Y Y Y Y

Section III. **Information About the Claim**

1. Type of claim:

○ Illness ○ Injury ○ Accident ○ Other *(please provide details of the incident including the date):* _____

1.a. If the claim is due to **illness**, provide the information below:

1. Date symptoms first appeared: M M / D D / Y Y Y Y
2. Date of first treatment: M M / D D / Y Y Y Y
3. Treating physician, clinic or hospital:

4. Were you hospitalized? ○ Yes ○ No
If yes, for how many days?

5. Have you experienced similar symptoms before? ○ Yes ○ No
If yes, when? M M / D D / Y Y Y Y

6. Do you have any chronic illness or disease? ○ Yes ○ No
If yes, diagnosis:
Date of diagnosis: M M / D D / Y Y Y Y

7. List any medications taken prior to visiting the doctor:

1
2
3
4

1.b. If the claim is due to **injury**, provide the information below:

1. Date of injury: M M / D D / Y Y Y Y
2. Place of injury:
3. Description of injury:
4. Did the injury occur on private property? ○ Yes ○ No

If yes, provide the following information:

4.a. Property insurance company name:
4.b. Insurance company phone number:
4.c. Policy number:
4.d. Property owner:
4.e. Claim number *(if applicable):*

Section III. **Information About the Claim** *(Continued)*

1.c. If the claim is due to **accident**, provide the information below:

1. Date of accident: M M / D D / Y Y Y Y
2. Place of the accident:
3. Description of accident:
4. Was the incident a motor vehicle accident? ○ Yes ○ No

If yes, provide the following information:

4.a. Vehicle insurance company name:
4.b. Policy number:
4.c. Claim number *(if applicable)*:
4.d. Vehicle owner name:
4.e. Vehicle owner phone number:

If more than one vehicle was involved, submit a separate sheet with the information on this section for each vehicle. For claims related to accidents, a police report may be required.

Section IV. **Information About the Insured's Physician**

Information about the insured's usual **physician** in his/her country of residence:

1. Last name:
2. First name:
3. M.I.:
4. Address:
5. City:
6. State:
7. ZIP code:
8. Country:
9. Phone number:
10. Fax number:
11. Email address:

Information about the insured's usual **pharmacy** in his/her country of residence:

1. Pharmacy name:
2. Phone number:
3. Address:
4. City:
5. State:
6. ZIP code:
7. Country:
8. Fax number:

Section V. **Information About the Services Provided and Claimed Expenses**

	DATE OF SERVICE	DESCRIPTION OF THE PROCEDURES/SERVICES RECEIVED	AMOUNT BILLED	AMOUNT PAID	CURRENCY
1	M M / D D / Y Y Y Y				
2	M M / D D / Y Y Y Y				
3	M M / D D / Y Y Y Y				

Section VI. **Other Payments and Insurance**

1. Do you have benefits available through other insurance?

○ Yes ○ No *If yes*, provide details below:

NAME OF THE INSURANCE PROVIDER	POLICY NUMBER	TELEPHONE NUMBER

Section VI. **Other Payments and Insurance** *(Continued)*

2. Have you claimed benefits from any other party?

○ Yes ○ No *If yes,* attach a copy of the settlement or denial.

If not, please state why:

Section VII. **Reimbursement Method**

○ Bank transfer

1. Bank name:

2. Bank address:

3. Account holder name:

4. Account number:

5. ABA / routing number / SWIFT code / BIC:

6. IBAN:

○ Check

1. Name:

2. Mailing address:

3. City:

4. State:

5. ZIP code:

6. Country:

If no choice of reimbursement method is selected, a check will be issued and mailed to the address listed in Section I. The reimbursement method cannot be changed once the claim has been processed.

Section VIII. **Certification and Authorization**

I certify that I have read and reviewed all answers and statements in this form and that, to the best of my knowledge, the information is complete and correct. I understand that any omissions, incomplete statements, or incorrect answers may result in the delay or denial of this claim.

I hereby authorize VUMI or VIP Universal Medical Group, Limited, its subsidiaries and affiliates to request my medical records and/or those of my dependents or travel companions, as well as any prescription drug history and any other medical or pharmaceutical information to be considered in the claim process for myself, my dependents or travel companions. I authorize any physician, hospital, laboratory, pharmacy or other medical provider, health plan, insurer, the Medical Information Bureau (MIB), or any other organization or person, including any family member who has medical records or knowledge of me or my health to disclose such information, or any other information required to process this claim, to VUMI or VIP Universal Medical Insurance Group, Limited or its designated representatives. Likewise, I hereby authorize VUMI or VIP Universal Medical Insurance Group, Limited and its subsidiaries and affiliates to disclose to my agent/insurance agency, affiliates, successors and the Medical Information Bureau (MIB) the terms of my policy, my certificate of coverage and other insurance documents, payment information, claims, reimbursement requests and medical records that may contain protected health information that will enable them to address my questions and facilitate interaction regarding my insurance coverage and claims payments. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

A photocopy of this authorization shall be as valid as the original.

1. Insured's full name *(or parent's/legal guardian's if the insured is a minor)*:

2. Insured's signature (*or parent's/legal guardian's if the insured is a minor*):

3. Date: M M / D D / Y Y Y Y