Non-Medical Benefits **Claim Form**

Use this form for personal accident, property loss or theft, travel delays, missed flight connections, hospital daily benefit, personal liability, or legal assistance claims. For baggage claims, use the Baggage Claim Form.

## 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.*

- ☐ Proof of travel.
  *For example: a copy of your trip itinerary, e-ticket or paper ticket, hotel, taxes, service fees and any other expenses.*

- ☐ A report from the treating physician(s), hospital, clinic and/or emergency room indicating the service dates, diagnosis and treatment (*if applicable*).

For **personal accident** claims:

- ☐ A report from the treating physician(s) indicating the treatment related to the accident.

For **property loss or theft**:

- ☐ A copy of the police report in case of fire, theft, robbery or burglary.
  *Claims without this report will not be considered.*
- ☐ Proof of ownership of lost, damaged or stolen items
  *For example: receipts, credit card statements, photos, instruction manuals, etc.*

For **missed flights**, **travel delays** of more than five (5) hours, **cancellations** or **overbooking**:

- ☐ Confirmation from the airline or transportation carrier indicating the cause of the delay and a statement with the carrier's compensation amount.
- ☐ Receipts of expenses for accommodations and/or meals.

For **hospital daily benefit** claims:

- ☐ A copy of the hospital invoice indicating the diagnosis and the admission and discharge dates.

For **legal assistance** claims:

- ☐ A copy of the bail notification and/or the court summons.
- ☐ Statement of the travel expenses to attend the court hearing.

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- ☐ 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(s)**

### Policyholder

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:

### Travel Companion(s)

| | FIRST NAME | M.I. | LAST NAME | GENDER | DATE OF BIRTH |
|---|---|---|---|---|---|
| 1 | | | | ○ Male ○ Female | M M / D D / Y Y Y Y |
| 2 | | | | ○ Male ○ Female | M M / D D / Y Y Y Y |
| 3 | | | | ○ Male ○ Female | M M / D D / Y Y Y Y |

## Section II. **Information About the Trip**

1. City and country of destination:

2. Date of departure: M M / D D / Y Y Y Y | 3. Scheduled date of return: M M / D D / Y Y Y Y

## Section III. **Information About the Claim**

1. Type of claim:

○ Personal accident ○ Property loss or theft ○ Travel delay or missed flight connection ○ Hospital daily benefit ○ Personal liability ○ Legal assistance

2. Where did the incident occur? | 3. Date: M M / D D / Y Y Y Y | 4. Time:

5. Description of the incident:

6. Are there any witnesses who can confirm the described events?

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

**WITNESS #1:**

1. Full name:

2. Address: | 3. Phone number:

**WITNESS #2:**

1. Full name:

2. Address: | 3. Phone number:

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

7. Has the incident been reported to the police or local authorities? *If not*, please state why:

○ Yes ○ No

If the claim is related to **theft**, **burglary** or **robbery:**

1. Where was(were) the object(s) kept?

2. Was(were) the object(s) kept in a locked place/compartment?

○ Yes ○ No

3. Were there any visible signs of forced entry? *If yes*, please explain:

○ Yes ○ No

4. Was(were) the object(s) stolen from a car?

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

4.a. Where in the car was(were) the stolen object(s) placed?

4.b. Was there any damage to the car? *If yes*, please describe the damage:

○ Yes ○ No

4.c. Registration number of the car: 4.d. Make and model of the car: 4.e. Name of rental car company (*if applicable*):

4.f. Car insurance company name and policy number:

## Section IV. **Schedule of Lost or Stolen Items**

| | STOLEN ITEMS | PURCHASE DATE | PRICE | CLAIMED AMOUNT | 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 | | | |
| 4 | | M M / D D / Y Y Y Y | | | |
| 5 | | M M / D D / Y Y Y Y | | | |
| 6 | | M M / D D / Y Y Y Y | | | |
| 7 | | M M / D D / Y Y Y Y | | | |

## Section V. **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 |
|---|---|---|
| | | |
| | | |

2. Have you claimed benefits from any other party?

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

## Section VI. **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 VII. **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