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.

- ☐ Proof of payment for your trip.
  For example: copy of credit and/or debit card statement, canceled checks or receipt from travel agency or supplier.

- ☐ Statement from your travel supplier indicating whether a refund and/or credit voucher has been issued or, if no refund and/or credit is available, a copy of the Cancellation Terms and Conditions of the booking(s).

If your trip was canceled or interrupted for **medical** reasons:

- ☐ A medical report from the treating physician indicating the reason for the trip cancellation.
  Further medical documentation may be required by your claims examiner.

- ☐ Copy of the death certificate (if applicable).

If your trip was canceled or interrupted for **non-medical** reasons:

- ☐ Supporting documents showing the reason for canceling or interrupting your trip.

- ☐ 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**

VUMI TRAVEL VIP

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) cancelling the same trip

	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
4				○ Male ○ Female	M M / D D / Y Y Y Y

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

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

4. Date the trip was purchased: M M / D D / Y Y Y Y

Section III. **Information About the Claim**

1. Type of claim:
○ Trip cancellation ○ Trip interruption ○ Trip delay

2. Reason for the claim:

○ **Illness**
1. Date symptoms first appeared: M M / D D / Y Y Y Y
2. Date physician was first seen for the condition: M M / D D / Y Y Y Y
3. Diagnosis:

○ **Injury/Accident**
1. Date of injury/accident: M M / D D / Y Y Y Y
2. Description of injury/accident:

○ **Death**
1. Date of death: M M / D D / Y Y Y Y
2. Cause of death:

○ **Other (*please explain*):**
1. Date incident occurred: M M / D D / Y Y Y Y
2. Date of trip cancellation: M M / D D / Y Y Y Y

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

3. Name of ill/injured/deceased person:

4. Gender: ○ Male ○ Female

5. Date of birth: M M / D D / Y Y Y Y

6. Relationship to the policyholder:

7. Name of treating physician:

8. Address:

9. City:

10. State:

11. ZIP code:

12. Country:

13. Phone number:

14. Email address:

Section IV. **Claimed Expenses**

Please specify the type of currency.

1. Cost of the cancelled trip:
2. Amount reimbursed by the travel agency or transportation carrier:
3. Claim amount:

Section V. **Other Payments and Insurance**

1. Do you have benefits available through other insurance?

○ Yes ○ No *If yes*, provide details in the section 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.

If not, please state why:

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