



Travel Medical & Incident Claim Form

Policyholder name: Educational & Institutional Insurance Administrators, Inc. (EIIA) Policy number: AHB0000013-241

Mailing Address: Everest Group, Ltd., Warren Corporate Center, 100 Everest Way, Warren, NJ 07059

Email: A&Hclaims@everestglobal.com

Phone: 908-635-8813 or 855-252-4695

General Inquiries: www.everestglobal.com/us-en/our-offer/products-and-services/insurance/claims/accident-and-health

Instructions:

1. **Please complete** the medical claim form in its entirety for each occurrence, then sign and submit to Everest.
2. Attach and **submit all itemized medical bills** for all amounts being claimed.*
* We recommend that you provide copies to us and keep the originals for yourself.
3. Submit **claim form** and **attachments** via mail or email (as shown above).

*****IMPORTANT:** *If your claim pertains to an Accident, you **must** complete the section labeled "IF IN AN ACCIDENT". If your claim pertains to a Sickness/Illness, you **must** complete the section labeled "IF SICKNESS/ILLNESS". Failure to complete one of these sections (whichever section pertains to your claim) will cause a delay and will result in us requesting that you complete this form again, including the required and necessary information needed to process your claim.*

Claimant information

Name of Claimant: _____

Date of Birth: ____ / ____ / ____ Social Security Number: _____ - _____ - _____

U.S. Address: _____
Street address Apt/unit # City State Zip code

Email: _____ Phone number: _____

Name of School/Program: _____ Location: _____

School/Program Start Date: ____ / ____ / ____ School/Program End Date: ____ / ____ / ____

Certification

I hereby certify the Claimant is an Insured of the Policyholder under the above Policy.

I certify that the information furnished by me is true and correct and complete according to the records of the Policyholder. I agree that this information is subject to audit by Everest and/or its representatives.

Name of Authorized Institution Official (please print): _____

Signature of Authorized Institution Official: _____

Title of Authorized Institution Official: _____ Date: ____ / ____ / ____

The policyholder certification can be skipped if the official travel approval form can be provided.

***** IF IN AN ACCIDENT**

Date of Accident: ____ / ____ / ____

Date of doctor/hospital visit: ____ / ____ / ____

Place of Accident: _____

Description/Details of injury (attach additional notes if necessary): _____

***** IF SICKNESS/ILLNESS**

Description/Details of Sickness/Illness (attach additional notes if necessary): _____

Onset date of symptoms: ____ / ____ / ____

Date of doctor/hospital visit: ____ / ____ / ____

Have you had this Sickness/Illness before? Yes No

If yes, when was the last occurrence and/or doctor/hospital visit? ____ / ____ / ____

For claims unrelated to a medical incident, please check the appropriate box below

In order to claim monies back related to one of the below benefits, you **MUST** submit the requested documentation.

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Trip cancellation | <input type="checkbox"/> Trip delay | <input type="checkbox"/> Trip interruption | <input type="checkbox"/> Baggage delay |
| <input type="checkbox"/> Evacuation | <input type="checkbox"/> Bedside visitor/reunion | <input type="checkbox"/> Counseling/therapy | <input type="checkbox"/> Other: _____ |

Please provide us with the relevant details of your incident below or the details and value of your loss. You may attach an additional page if necessary: _____

Reimbursement

Have these doctor/hospital bills been paid by you? Yes No

If yes, **you must include the payment receipt(s)**. Any eligible reimbursements will be made in U.S. currency (USD) via check.

Payment is typically processed in the form of a check. If you prefer an ACH, please be sure to provide relevant banking information in your email.

Please note that if you are submitting a claim for prescription medication, you must submit the prescription receipt. This will include your name, the name of the prescribing physician, name of the medication, dosage, date and amount billed. Cash register receipts will not be considered for reimbursement.

Required Documentation - Please attach copies of the following documents as applicable:

- Medical information from the claimant's file relating to this injury/illness or accident, if available
- Incident/police reports relating to the incident, if applicable
- Written report from common carrier management indicating reason and the duration of such delay interruption
- Written report from common carrier management indicating reason and the duration for baggage delay, misdirection or misplacement
- Purchase receipts for lost items
- Quotation for repairing damaged items
- Official receipts for additional travel expenses incurred
- Official receipts for expenses incurred, such as replacement cost of luggage, passport or ticket

Consent to release medical information

I hereby authorize any insurance company, hospital or physician or other person who has attended or examined me, including those in my home country, to furnish Everest or any of their duly appointed representatives, any and all information with respect to any sickness/illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital and medical reports. A photostatic copy of this authorization shall be considered as effective and valid as the original.

I certify that the information furnished by me in support of this claim is true and correct.

Claimant name (please print): _____

Signature: _____

Date: ____ / ____ / ____

FRAUD STATEMENTS

APPLICABLE IN ALABAMA, ARKANSAS, MARYLAND, NEW MEXICO, TEXAS, and WEST VIRGINIA

Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to (civil)** fines and (criminal penalties)** confinement in prison. *Applies in MD only. ** Applies in NM only.

APPLICABLE IN ALASKA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, KENTUCKY, LOUISIANA, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW JERSEY, NORTH DAKOTA, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, UTAH, WISCONSIN, and WYOMING

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and/or imprisonment.

APPLICABLE IN ARIZONA

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

APPLICABLE IN CALIFORNIA

General: For your protection California law requires the following to appear on this form.

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

APPLICABLE IN COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or

information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICABLE IN DELAWARE

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

APPLICABLE IN DISTRICT OF COLUMBIA

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

APPLICABLE IN FLORIDA

General: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

APPLICABLE IN HAWAII

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

APPLICABLE IN LOUISIANA

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.

APPLICABLE IN MAINE

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

APPLICABLE IN NEW HAMPSHIRE

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

APPLICABLE IN NEW YORK

General: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

APPLICABLE IN NORTH CAROLINA

Any person who knowingly presents false information in an application for insurance or viatical settlement contract or a viatical settlement purchase agreement is guilty of a felony and may be subject to fines and confinement in prison.

APPLICABLE IN OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

APPLICABLE IN OKLAHOMA

General: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

APPLICABLE IN OREGON

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application or by filing a claim containing a misstatement, misrepresentation, omission, or false statement as to any material fact may be committing a fraudulent insurance act, which may be a crime and subject the person to criminal and civil penalties.

APPLICABLE IN PENNSYLVANIA

General: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

APPLICABLE IN TENNESSEE, VIRGINIA AND WASHINGTON

General: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.