Cultural Insurance Services International – Claim Form

- **Program Name:** Wheaton College
- **Policy Number:** GLM N0496522A
- **Participant ID Number** (from the front of your insurance card)**:**

Mailing Address: **1 High Ridge Park, Stamford, CT 06905 |** ***E-mail:*** **claimhelp@mycisi.com |** ***Fax:*** **(203) 399-5596**

For claim submission questions, call (203) 399-5130, or e-mail claimhelp@mycisi.com

Instructions:

1. Fully complete and sign the medical claim form for each occurrence, indicating whether the Doctor/Hospital has been paid.
2. Attach **itemized bills** for all amounts being claimed. *We recommend you provide us with a copy and keep the originals for yourself.
3. Approved reimbursements will be paid to the provider of the service unless otherwise indicated.
4. **Submit claim form and attachments via mail, e-mail, or by fax** *(provided above).*

► NAME AND CONTACT INFORMATION OF THE INSURED

Name of the Insured:_____ Date of Birth:_____/_____/_____
(month/day/year)

*Please indicate which is your home address: ☐ U.S. Address ☐ Address Abroad

U.S. Address:_____
street address apt/unit # city state zip code

Address Abroad: _____

E-mail Address:_____ Phone Number: _____

► IF IN AN ACCIDENT

Date of Accident:_____/_____/_____ Place of Accident:_____ Date of Doctor/Hospital Visit:_____/_____/_____

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

_____

► IF SICKNESS/ILLNESS

Description 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? _____

► REIMBURSEMENT

Have these doctor/hospital bills been paid by you? ☐ YES ☐ NO

If no, do you authorize payment to the provider of service for medical services claimed? ☐ YES ☐ NO

If yes, any eligible reimbursements will be made in U.S currency (USD) via check. If you would like your eligible reimbursement in another currency via wire transfer, please contact CISI at 203-399-5130 or claimhelp@mycisi.com for instructions.

Please note 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.

► 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 to Cultural Insurance Services International 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 or medical reports. A photo static 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.

Warning: Any person who, knowingly or with intent to defraud or to facilitate a fraud against any insurance company or other person, submits an application or files a claim for insurance containing false, deceptive or misleading information may be guilty of insurance fraud.

Name (please print) _____

Signature_____ Date_____