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).

See next page for state specific disclaimers , claimant cooperation p rovision and additional claim submission instructions.

*** IMPORTANT: If your claim pertains to a n Accident, SECTION 2MUST be completed. If your claim pertains to a Sickness/Illness, SECTON 3 MUST be completed. Failure to complete one of these sections (whiche ver section pertain s to your claim) , will ca use a delay as we will request for you to complete this form again to include this necessary information in order to process your claim. For claims rela ted to one of the Travel As sistance Benefits, see Section 5.

SECTION 1: NAME AND CONTACT INFORMATION OF TH E INSURED

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

*Plea se indicate which is your home address: ...U.S. Address ... Address Abroad

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

Address Abroad: _____

E-mail Address: _____ Phone Number: _____

SECTION 2: IF IN AN ACCIDENT***

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

Description/Details of Injury (attach additional not es if necessary):_____

_____

SECTION 3: 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 yesf****aCBAGGAGE__.dnyoo58 ( )]TJ ET q 0 0 612 792 re W n BT 0.149 G 0.214 w /C2_0 1 Tf 0 Tc 0 Tw 2

...EMERGENCYMEDICAL REUNION ...CHAPERONE REPLACEMENT

Please provide us with the rel evant detail s of your incident below or the deta ils and value of your lo ss. You may attach an additional page if( )8 .1 (d)h th a6(age)5 0ten

Instructions f or Claim Subm ission on Unrelated to a Medi cal Incident

For residents of Pennsylvania: Any person who knowingly and with the 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.

For cl aiman ts not residing in Alabama, Arkansa s Calif or nia, Color