

Medical Claim Form



The claimant should pay the hospital/doctor the US \$50 deductible.
Accident and sickness proof of loss form and blanket policies. Policy number aifs 01-04

Name of Person Making the Claim _____

Membership Number _____ Date of Birth _____
dd/mm/yyyy

Resort Address _____

Home Address _____

Policy Holder RESORT AMERICA- AMERICAN INSTITUTE FOR FOREIGN STUDY

Policy Validity and Program Dates MAY 1, 2007 - OCTOBER 31, 2007 (153 days maximum)

Address of Organization Resort America, River Plaza, 9 West Broad Street, Stamford, CT 06902-3788 USA, Tel. 203-399-5130

Doctor in Attendance _____ Hospital _____

To whom are payments to be made? _____

IF IN AN ACCIDENT

Date and Time of Accident (a.m. or p.m.) _____
dd/mm/yyyy

Place of Accident _____

Nature of Injury _____

What happened? _____

Describe activity engaged at time of accident _____

Who was present? _____

IF IN SICKNESS

Nature of Illness _____

Date Illness Commenced _____ Date you Plan to Return Home _____
dd/mm/yyyy *dd/mm/yyyy*

If you have paid more than the \$50 deductible and are claiming money back, please circle which currency you would like the check to be paid in:

Sterling U.S. Dollars Australian Dollars Danish Krone Euros Swedish Kroner

I hereby authorize any insurance company, hospital or physician to release all information which may have a bearing on benefits payable under this plan. I certify the information furnished by me in support of this claim is true and correct.

Signature _____ Date _____
dd/mm/yyyy

Claims should be forwarded to:
Cultural Insurance Services International
River Plaza, 9 West Broad Street, Stamford, CT 06902-3788 USA
Tel. 203-399-5130/203-399-5132.