WorldTrips
PO Box 240358
Apple Valley, MN 55124
800-605-2282 / 1-317-262-2132

INDIANA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Claimant's Statement and Authorization

INSTRUCTIONS

COMPLETE ALL APPLICABLE PARTS OF THIS FORM.

NOTE: *Only one Claimant's Statement and Authorization form is required for each episode of care. If you have already submitted a form related to the incident for which you are claiming, an additional Claimant's Statement is not needed.*

MEDICAL SERVICES OUTSIDE THE UNITED STATES

If medical services took place outside the United States, please complete this form along with Supplement A. Attach copies of all itemized bills for service and supplies. Please verify that the documents indicate your name, date of service, diagnosis, and the charge for each service. If you have already paid for these services, please include receipts showing payment.

FORM SUBMISSION OPTIONS

If you are NOT completing and submitting this form online via Member Portal, you must send us the completed form using one of the methods below.

Online Submission — Go to:
https://service.worldtrips.com/
OR
https://worldtrips.my.site.com

Paper Form – Mail to:
WorldTrips
PO Box 240358
Apple Valley, MN 55124
U.S.A

QUESTIONS OR GUIDANCE

For questions or guidance in filling out this form, please visit https://www.worldtrips.com/claims-resource-center. You can also call us toll-free at 800-605-2282 within the U.S. or collect at 1-317-262-2132 from anywhere else in the world. When calling, please mention the country and area code that you are calling from.

PART A: CLAIMANT INFORMATION

1A. Claimant's Full Name:		**2A. Gender:**	**3A. Date of Birth (MM/DD/YY):**
4A. Current Mailing Address:			
5A. City:	**6A. State:**	**7A: Postal Code:**	**8A. Country:**
9A. Primary Telephone:	**10A. Secondary Telephone:**	**11A. Email Address:**	
IMPORTANT: We CANNOT process your claims without the correct ID Number. You can locate this number on your Policy Document or Policy ID Card.		**12A. Policy Number or Certificate Number:**	
13A. Citizenship:	**14A. Home Country*:**	**15A. Countries Visited:** (WorldTrips may request a copy of your passport.)	

* Home Country is where you principally reside & receive regular mail.

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PART A: CLAIMANT INFORMATION (Continued)

16A. Are you a full-time student? ☐ Yes ☐ No - **If YES, please provide the following:**			
Name of School:			
Address of School:			
City:	**State:**	**Postal Code:**	**Country:**
IMPORTANT - Be Sure to Attach: • If in the United States, a copy of your valid, education-related visa (F-1 or J-1 visa, OPT, etc.) and/or valid I-20 / DS2019 • Proof of your full-time student status (please disregard this item only if you are submitting a copy of a valid F-1, including OPT, or J-1 visa.)			
17A. Are you employed? ☐ Yes ☐ No			
18A. Do you have any other coverage (medical, indemnity, or liability), other than that provided by WorldTrips, which might help cover claimed expenses? ☐ Yes ☐ No			
Name of Insurance Company:	**Policyholder:**	**Policy Number:**	**Effective Date (MM/DD/YY):**
Address:			
City:	**State:**	**Postal Code:**	**Country:**
Is this group insurance? ☐ Yes ☐ No	**Is this insurance obtained through a university or school that you attend?** ☐ Yes ☐ No		

PART B: TRAVEL ASSISTANCE AND OTHER CLAIMS

This section relates to benefits not necessarily related to illness, accidents or injury. If none of the following applies to you, please feel free to skip PART B and proceed to PART C: Medical Information

1B. Please check all you are applying for:

☐ **Travel Delay** ☐ **Lost Checked Luggage** ☐ **Trip Interruption**
☐ **Emergency Quarantine Indemnity Benefit — Covid-19** ☐ **Other** _____

2B. Please provide as detailed as possible (including dates, times, locations) of incident:

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PART C: MEDICAL INFORMATION

1C. If regarding illness or injury, please provide the following details:

Onset of illness or date and time of injury:	If accident, location of that accident (please be as specific as possible):
How did the illness or injury/accident begin? State fully all symptoms and describe in detail from the beginning, including first date of onset.	

2C. Have you ever had or been treated for the same kind of illness or injury? ☐ Yes ☐ No - If YES, please provide the following:

Date Treated (MM/DD/YY):	Attending Physician's Name:	Attending Physician's Telephone:
Attending Physician's Address:		

City:	State:	Postal Code:	Country:

3C. If in an accident, was it involving a motorized vehicle? ☐ Yes ☐ No
If YES, please include a copy of the police report and complete the following regarding the insurance of the vehicle(s) involved:

Insurance Company Name:	Insurance Company Address:	Insurance Company Telephone:

4C. Have you had any ailments, diseases, illnesses, conditions, or injuries, or have you taken any medications during the last 2 years?
☐ Yes ☐ No If YES, please provide the following:

Name/Description of Condition or Medication	Date(s) (MM/DD/YY)	Physician Name	Physician Address	Physician Telephone

5C. Was the incident related to your employment? ☐ Yes ☐ No If YES, please provide the following:

Employer Name:	Employer Telephone:
Employer Address:	

City:	State:	Postal Code:	Country:

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PART D: MEDICAL RECORD AUTHORIZATION

1D. VERIFICATION

I verify that all information contained in this form is true, correct, and complete to the best of my knowledge. I authorize any licensed doctor, practitioner of the healing arts, hospital, clinic, health-related facility, pharmacy, government agency, insurance company, group policyholder, employee, or benefit plan administrator having information as to the care, advice, treatment, diagnosis, or prognosis of any physical or mental condition, or the financial or employment status of the insured named below, to provide this information to WorldTrips. I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be as valid as the original. This authorization is valid for twelve months from the date signed:

Claimant's Signature

Print Name

Date (MM/DD/YY)

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SUPPLEMENT A — CLAIM ITEMIZATION FORM

This form is required for itemization of expenses being claimed for reimbursement by the insured. Please ensure that you include a copy of the invoice / receipt for all expenses being listed. Any expenses requesting payment directly to the provider, please indicate with "Pay to Provider". If you have no expenses to claim, please list "N/A".

Date of Service (MM/DD/YY)	Provider	Diagnosis	Description of Services	Currency	Country	Amount Charged

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SUPPLEMENT B — PAYMENT AUTHORIZATION AGREEMENT FORM

The insured hereby authorizes WORLDTRIPS to initiate credit entries to the account indicated below at the depository financial institution named below. It is also acknowledged that the origination of WIRE transactions to the specified account must comply with the provisions of U.S. law. **Check payments are limited to addresses in the USA and Canada.**

1. Beneficiary Name:	**2. Home Telephone** (if applicable)**:**		**3. Email Address** (if applicable)**:**
4. Beneficiary Address:			
5. City:	**6. State:**	**7. Postal Code:**	**8. Country:**

Payment Type: ☐ **Check (Complete Above Section)** ☐ **Wire/ACH Transfer (Complete Applicable Section Below)**

Special notes regarding international wires:

a) WorldTrips pays all initial wire fees. However, international wire transfers may incur currency conversion fees. Also, the use of an Intermediary bank may also incur additional fees. These additional fees are the responsibility of the payee.
b) Mexico - wires must have a CLABE # (18 digits)
c) Great Britain - wires in US dollars must have a bank account# and a Sort Code (6 digits)

International Bank Accounts (Banks outside of the United States)

All wires or ACH (Automated Clearing House) payments are sent in USD. To ensure timely delivery of payment, it is recommended that the member contact their bank to confirm wire or ACH instructions and that their bank can accept payment USD. Sending international wires without the required information can cause the wire to be delayed or returned.

9. Bank Name:	**10. Bank City:**	**11. Bank Country:**
12. Swift Code:	**13. Account Holder Name:**	**14. Account Holder Address:**
15. Account Holder City:	**16. Account Holder Providence:**	**17. Account Holder Country:**
18. Bank Account Number:	**19. IBAN Number (if applicable)**	

Intermediary Bank (If Applicable) (U.S. bank that converts USD payment to foreign currency. Only needed if receiving bank cannot accept and convert USD payment to foreign currency)

Important: If the receiving bank resides outside the United States. please inquire from your foreign bank if they require the use of an Intermediary (correspondent) bank in order to receive a wire transfer from a U.S. bank. If this is true, then please obtain the following required information regarding your bank's Intermediary bank.

20. Bank Name:	**21. Bank City:**	**22. Bank State:**
23. ABA / Routing Number (9 digits):	**24. Account Number** (if applicable)**:**	
25. Any special instructions for forwarding payment:		

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SUPPLEMENT B: PAYMENT FORMS (Continued)

Domestic Payments (U.S. Banks) There are two methods for bank-to-bank electronic payments: Wire Transfer and Automated Clearing House (ACH) routing number to identify your bank will differ depending on which payment method is used.		
ACH (Automated Clearing House) — U.S. Bank Only		
26. Bank Name:	**27. Bank City:**	**28. Bank State:**
29. Account Holder Name:	**30. Account Holder Address:**	**31. Account Holder City:**
32. Account Holder State:	**33. Account Holder Zip Code:**	**34. Bank Routing Number (9 digits):**
35. Account Number:	**36. Checking Account:** ☐	**Savings Account:** ☐

Printed Name of the Insured Person | **Insured Signature** | **Date (MM/DD/YY)**

PARENT / GUARDIAN OR THIRD-PARTY PAYMENT AUTHORIZATION

Please complete this section if payment is to be made to a third-party other than the insured. Please sign to indicate authorization for us to reimburse this person. **This section is required to be completed for any payment made to parents / guardians of the insured.** Please include any wire account details in the applicable box above.

1. Name:			
2. Address:			
3. City:	**4. State:**	**5. Postal Code:**	**6. Country:**

I authorize payment of benefits to the third party listed above.

Printed Name of the Party Completing Form

Signature | **Date (MM/DD/YY)**

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SUPPLEMENT D — AUTHORIZATION FORM FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

You must fill out the sections below if you wish to authorize WorldTrips to disclose your protected health information to another party.

Supplement D authorizes WorldTrips to use and/or disclose your protected health information ("PHI") to individuals you specify. For the purpose of this form, PHI shall be considered protected health information, which is individually identifiable health information received from or maintained by WorldTrips. **Without completing and signing Supplement D, Federal law prohibits WorldTrips from releasing your PHI to your spouse, parent, adult children, or other family members, close personal friends, or other personal representatives unless you are present at the time of disclosure.**

No benefits will be withheld from you if you refuse to sign Supplement D.

SECTION A: Insured Authorizing Use and/or Disclosure

Insured Name: _____

Policy/Certificate Number: _____

SECTION B: The Use and/or Disclosure Being Authorized

The information to be used and/or disclosed is (select all that apply):

- ☐ Claims & payment data
- ☐ Eligibility and enrollment
- ☐ Bills, requests for payment
- ☐ Payments or coverage under the policy / certificate
- ☐ Other (please specify) _____

Purpose for this use and/or disclosure:

- ☐ At my request
- ☐ Other (please specify) _____

Persons this information may be disclosed to:

1. _____ Relationship to insured _____
2. _____ Relationship to insured _____
3. _____ Relationship to insured _____
4. _____ Relationship to insured _____

SECTION C: Expiration

This authorization will expire (complete one):

- ☐ On _____/_____/_____ (MM/DD/YY)
- ☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized): _____

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SUPPLEMENT D: AUTHORIZATION FORM FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (Continued)

SECTION D: Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time by notifying WorldTrips in writing, but the revocation will not have any effect on any actions that WorldTrips took before we received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive health care benefits to which I am otherwise entitled.
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity and I understand that the information may no longer be protected by the Health Insurance Portability Accountability Act of 1996 (also known as HIPAA).

Insured's Signature

I, having had the full opportunity to read and consider the contents of this authorization, hereby authorize WorldTrips to use and/or disclose my protected health information as indicated above.

_____ _____

Signature **Date (MM/DD/YY)**

If this authorization is signed by a personal representative on behalf of the insured/ certificate holder, complete the following:

Personal Representative's Name: _____

Relationship to Insured/ Certificate Holder for Whom This Authorization Applies: _____

Note: If requested, you must provide valid and current proof of your legal relationship as a personal representative.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

A copy of this form may be used as if it were an original.