GENERALI GLOBAL ASSISTANCE

Dear Policyholder:

Please complete and sign the attached claim form. Additionally, the following items are needed in order to process your **Medical/Dental** claim in the most efficient and expedient way possible.

SPECIAL NOTE FOR MEDICARE AND TRICARE POLICYHOLDERS: The plan you purchased may be in excess to any other health insurance you may have (Medical or Dental). For foreign medical treatment, if you are a Medicare policyholder with a supplemental carrier, we will require a disposition from the supplemental carrier, as most will pay some foreign expenses (even though Medicare will not). If you are a TriCare policyholder with a supplemental carrier, for foreign and domestic treatment, we will require the disposition from the supplemental carrier, as most will pay some foreign expenses (our policy is primary to TriCare only). For both Medicare and TriCare policyholders, you must indicate on the claim form if you do not have a supplemental health plan and sign the enclosed Affidavit of No Insurance.

What you should provide:

- A signed and completed "Patient Authorization Form." Due to HIPAA (Health Information Portability and Accountablity Act) requirements, we must request that the patient or their authorized legal representative sign and complete the enclosed form in its entirety. Authorized legal representatives must include a copy of their designation as such. **Failure to provide this documentation may result in a delay of your claim;**
- The disposition of your claim with your primary insurance and supplemental insurance carriers. Note: this may not apply to residents of New York, please review your Description of Coverage or Policy for details;
- If you did not have any health insurance in effect at the time you incurred your expenses, please complete and sign the attached Affidavit of No Insurance;
- An itemized list of all related bills, including dates, diagnoses, and amounts claimed as well as the names, addresses, and telephone numbers of all doctors and hospitals where the patient was treated. Please include copies of the actual bills for consideration;
- Actual proof of payment for your trip, such as credit card statements or copies of the front and back of cancelled checks. **Invoices will not be accepted as actual proof of payment;**
- Proof of age for all parties making a claim, such as copies of driver's licenses or passports. If any parties are minors, please provide the names and addresses of their parents or legal guardians. If multiple parties are making a claim, please state their relationship to one another;
- Please note: if you are emailing your claim, our system does not accept files over 10MB in size.

EACH PARTY MAKING A CLAIM MUST SIGN THE COMPLETED CLAIM FORM.

Written proof of loss must be sent to us within 90 days after the date the loss occurs. We will not reduce or deny a claim if it was not reasonably possible to give us written proof of loss within the time allowed. In any event, you must give us written proof of loss within twelve (12) months after the date the loss occurs unless you are medically or legally incapacitated.

Thank you. Should you have any questions, please call us at (800) 541-3522.

MEDICAL EXPENSE CLAIM FORM

GENERALI GLOBAL ASSISTANCE

IMPORTANT: ALL PAGES OF THIS CLAIM FORM MUST BE COMPLETED IN FULL AND SIGNED. FAILURE TO DO SO MAY DELAY THE PROCESSING OF YOUR CLAIM.

SECTION 1: PERSONAL & TRAVEL INFORMATION

NAME OF INSURED		POLICY/REFERENCE #		SCHEDULED TRAVEL DATES
BOOKING/RESERVATION #	DATE OF BIRTH	HOME/CELL PHONE	BUSINESS PHONE	EMAIL ADDRESS
INSURED MAILING ADDRESS		CITY	STATE	ZIP CODE
CO-INSURED/TRAVELING COMPANION(S)	DATE OF BIRTH	HOME/CELL PHONE	BUSINESS PHONE	EMAIL ADDRESS
CO-INSURED/TRAVELING COMPANION(S) MAILING ADDRESS		CITY	STATE	ZIP CODE
TRAVEL AGENT/RENTAL COMPANY	TRAVEL AGENT'S NAME	TELEPHONE	EMAIL ADDRESS	
TRAVEL AGENT'S MAILING ADDRESS		CITY	STATE	ZIP CODE

SECTION 2: DETAILS OF SICKNESS OR INJURY

NATURE OF SICKNESS OR INJURY	DATE FIRST TREATED
DATE SICKNESS FIRST BEGAN. IF INJURY, PLEASE LIST DATE AND TIME INJURY OCCURRED.	IF INJURY, HOW AND WHEN DID ACCIDENT OCCUR?
WAS ACCIDENT REPORT COMPLETED FOR THIS INCIDENT? IF YES, PLEASE PROVIDE COPY	WERE YOU TREATED FOR THIS CONDITION PRIOR TO THE PURCHASE OF YOUR TRIP? IF YES, PLEASE LIST ALL DATES:
IF YES TO PRIOR QUESTION, PLEASE PROVIDE NAME, ADDRESS AND PHONE NUMBER OF TREATING PHYSICIAN	

SECTION 3: MEDICAL FACILITIES (LIST ALL MEDICAL FACILITIES WHERE TREATMENT WAS SOUGHT FOR THIS CONDITION)

MEDICAL PROVIDER NAME	ADDRESS	TELEPHONE	FAX	DATES
MEDICAL PROVIDER NAME	ADDRESS	TELEPHONE	FAX	DATES
MEDICAL PROVIDER NAME	ADDRESS	TELEPHONE	FAX	DATES

SECTION 4: OTHER INSURANCE INFORMATION

DO YOU HAVE OTHER HEALTH/MEDICAL INSURANCE? ☐ YES ☐ NO

HAVE YOU SUBMITTED A CLAIM TO YOUR PRIMARY/SUPPLEMENTAL INSURANCE CARRIER? ☐ YES ☐ NO **(If not, please do so)**

PRIMARY HEALTH OR DENTAL INSURANCE COMPANY	POLICY NUMBER	PHONE NUMBER
SUPPLEMENTAL HEALTH OR DENTAL INSURANCE COMPANY	POLICY NUMBER	PHONE NUMBER

PLEASE COMPLETE OTHER SIDE

SECTION 5: DESCRIPTION OF MEDICAL EXPENSES AND AMOUNT CLAIMED

PLEASE LIST ALL MEDICAL EXPENSES INCURRED AS A RESULT OF THIS SICKNESS/INJURY. ENCLOSE COPIES OF MEDICAL BILLS, REPORTS, AND EXPLANATION OF BENEFITS FROM YOUR PRIMARY AND SUPPLEMENTAL HEALTH OR DENTAL INSURANCE COMPANY.

NAME OF DOCTOR/HOSPITAL	DATE TREATED	AMOUNT OF BILL	AMOUNT PAID BY OTHER INSURANCE	AMOUNT CLAIMED
			LESS AMOUNT RECEIVED FROM OTHER SOURCES	
Notice: If you have more items, please attach separate sheet			**TOTAL AMOUNT CLAIMED** (including additional items if attached)	

FRAUD WARNINGS AND DISCLOSURES

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.

Alaska, Minnesota, New Hampshire: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arkansas, Louisiana, New Mexico, Texas, West Virginia: 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 civil fines and criminal penalties.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to any 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 from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Maine, Virginia, Tennessee, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company 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.

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

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self insured program files a statement of claim or an application containing any false or misleading information is guilty of a felony of the third degree.

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.

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.

Oklahoma: 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.

Kentucky, Pennsylvania: 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.

Kansas: 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 may be guilty of insurance fraud as determined by a court of law.

Maryland: 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.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: 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 violation.

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.

Oregon: Any person who knowingly and with intent to defraud, files a claim for benefits may be guilty of insurance fraud and may be subject to prosecution.

☐ By checking this box, I/we, the insured(s), agree that my/our electronic signature(s) shall be the legal equivalent of my/our manual signature(s) on the document. I/we, the insured(s), attest that all the statements in this document are true and complete to the best of my/our knowledge. I/we authorize Generali Global Assistance to contact me/us or anyone else involved in this matter, to verify whether or not this loss occurred. I/we further authorize Generali Global Assistance to release and share claim information including that which may be used in the identification and prevention of potential fraudulent activity to Generali U.S. Branch, Generali Assicurazioni Generali S.p.A. (U.S. Branch), Assicurazioni Generali – U.S. Branch, Generali U.S. Branch DBA The General Insurance Company of Trieste & Venice, The General Insurance Company of Trieste and Venice – U.S. Branch, insurance support organizations, fraud information clearinghouses, designated service providers and business associates assisting in the processing of the claim.

INSURED'S SIGNATURE | PRINT NAME | DATE

GENERALI GLOBAL ASSISTANCE

Patient Authorization Form

Name of Patient:_____ Date of Birth:_____

SS# _____ Purpose of release: TRAVEL INSURANCE CLAIM

Claim # _____ Policy # _____

DOCTORS AND/OR MEDICAL FACILITIES AUTHORIZED TO RELEASE MY HEALTH INFORMATION:

Name	Address	Telephone	Fax	Dates Treated

You are authorized to provide Generali Global Assistance, its affiliates, underwriters, and any agent acting on behalf of Generali Global Assistance, with any health information concerning insurance coverage, medical care, advice, treatment, including HIV/AIDS testing, drug or alcohol abuse records, mental health records, or any other information that may have bearing on the claim for benefits submitted under the travel insurance plan.

Send to: Generali Global Assistance
Attn: Claims Department, P.O. Box 939057, San Diego CA 92193-9057
FAX: 877-300-8670
Information to be released: Physician Dictation, Physical and/or Occupational Therapy Records, Office Notes, Lab Reports, Entire Record, Other:_____

I UNDERSTAND THE FOLLOWING:

- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. Revocation of this authorization must be in writing and will not affect information already disclosed.
- Unless revoked, this authorization will expire in six months.
- I have the right to receive a copy of this authorization.
- Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy regulations.
- My treatment, payment, or enrollment may not be conditioned on signing this authorization. If I refuse to sign this authorization, benefits may not be paid under the travel insurance plan if additional health information is needed to determine my eligibility for benefits.

Signature of patient or authorized person Date:

If signed by an authorized person, please state your legal authority to act for the patient (e.g., parent, power of attorney, executor). Attach supporting legal documentation.

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AFFIDAVIT OF NO INSURANCE

I/we, _____ hereby declare under penalty of perjury that I/we do not have any other valid and collectible insurance or indemnity coverage, including, but not limited to, primary/supplemental medical insurance, Medicare, or other travel insurance policies that were in effect during the covered trip.

_____ _____
Signature Date

_____
Print Name

_____ _____
Signature Date

_____
Print Name

_____ _____
Witness Signature Date

_____
Print Name