WORLD CLASS TRAVEL PROTECTION
MEDICAL CLAIM FORM

Please mail completed Claim Form with itemized bills and receipts to:
(To expedite your claim, please fax it with readable receipts)

ACE USA
1 Beaver Valley Road
PO Box 15417
Wilmington, DE 19850 USA

(800) 336-0627 Inside USA
(302) 476-6194 Outside USA
(302) 476-6154 Facsimile
diane.basa@ace-ina.com

Please complete Sections A and B. Complete Section C if the claim is for a dependent, other coverage is in effect, or if the claim is accident related. Complete a separate Claim Form for each individual.

SECTION A. EMPLOYEE/PATIENT INFORMATION

Employer: _____ Policy: _____

Employee's Name _____ Employee's Date of Birth _____

Patient's Name _____ Patient's Date of Birth _____

Home Address _____

Please provide telephone and facsimile numbers, with country and city codes.

Home #_____ Work # _____ Fax #_____ E-mail_____

Manager's Name _____ Work #_____ Fax # _____ E-mail_____

SECTION B. TRAVEL INFORMATION *Please complete this section*

My Business location is in (country of employment) _____

I / we left the above country on (Day / Month / Year) _____

I / we visited the following countries _____

I / we are expected to return home on (Day / Month / Year) _____

The purpose of my / our trip was _____

SECTION C. PAYMENT INFORMATION *Please complete either Option #1 or Option # 2*

μ OPTION #1 (Payment to EMPLOYEE) ***Please indicate where you wish the payment to be sent and in what currency.***
μ Your home address as listed above

μ OPTION #2 (Payment to a Provider, e.g. hospital, physician)
Please complete Provider's name and address in Section E of this Claim Form

Payment Authorization: I authorize payment directly to me or to the healthcare provider in Section E of this Claim Form.

EMPLOYEE'S SIGNATURE_____ **DATE** _____

Patient's Signature and Release (Parent or Guardian, if claim is for a minor), I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine claim payment.

PATIENT'S SIGNATURE: _____ **DATE:**_____

SECTION D. OTHER COVERAGE INFORMATION

Complete only if the claim is for a dependent and/or other coverage is in effect or if the claim is accident or work related.

Do you have any other insurance? μ Yes μ No If yes, please provide source of insurance.

Please indicate source _____

Is this claim accident related? μ Yes μ No Is this claim worked related? μ Yes μ No

If yes, please provide documents relating to accident or work injury.

If claim is due to an accident, are you seeking reimbursement from another source? μ Yes μ No

Please indicate source _____

Spouse's name _____ Spouse's insurance company _____

Spouse's employer and telephone # _____

Dependent's date of birth _____ Is your dependent a full-time student? μ Yes μ No

If yes, please provide documentation of current academic registration.

SECTION E. PHYSICIAN OR PROVIDER *Please complete this section.*

Name, address, and telephone # of physician or provider of service_____

_____

Diagnosis or nature of illness or injury _____

Date of illness (first symptom) or injury _____ Date first consulted for this condition _____

Hospital confinement dates: From _____ To _____ Date able to return to work _____

Total disability dates: From _____ To _____ Partial disability dates: From_____ To _____

Patient's account # _____ Amount paid _____ Balance due _____

Place of service _____ Diagnosis code and description _____

Date of Service	Procedure code and description/ Predetermination of benefits	Charges	Total charges

WARNING: Any person who files a statement of claim containing any false, incomplete, or misleading information, who knowingly and with intent to injure, defraud, or deceive any insured, is guilty of a crime.