Hospital, Medical or Emergency Medical Evacuation Claim Form

How to Submit a **Claim**

All claims must be reported within one hundred and eighty (180) days of occurrence.

1. Gather all your claim documentation.
   You are responsible for any fees charged for issuing supporting documentation that may be required.
2. Complete and sign the claim form.
   The claim form must be completed by the insured or by a parent or legal guardian if the insured is a minor.
3. Mail all documentation to:

For Claims in the U.S.:
Epic Americas
PO Box 21150
Eagan, MN, 55121

For Claims elsewhere:
25 Millard Ave W, 2nd Floor
Newmarket, ON L3Y 7R5, U.S.

4. *You can also submit your claim online through the MyVUMI™ portal.*

Claim **Checklist**

- ◯ The fully completed claim form, signed and dated.
  Incomplete claim forms will be returned to you, and this will delay the processing of your claim submission.
- ◯ All invoices and payment receipts.
- ◯ For annual trip plans: proof of departure from the country of residence.
  For example: boarding pass; plane ticket; copy of stamped passport; if driving, credit or debit card statement showing purchases before leaving state/province and after arriving at destination.
- ◯ A report from the treating physician, hospital, clinic or emergency room indicating the service date and diagnosis.
- ◯ A copy of all prescriptions for medication.
- ◯ A copy of a police report in case of an accident.
- ◯ A copy of all documents for your records.

CLAIM FORM BEGINS ON THE NEXT PAGE

SUBMIT COMPLETED FORMS AND SUPPORTING DOCUMENTATION TO:

claimstravelvumi@epicamericas.com

or

For Claims in the U.S.:
Epic Americas
PO Box 21150
Eagan, MN, 55121

For Claims elsewhere:
625 Cochrane Dr, 4th Floor,
Markham, On L3R 9R9, Canada

TO CHECK CLAIM STATUS, CONTACT:

Toll-Free (U.S. and Canada): +1.888.809.3493

Collect (Worldwide): +1.416.744.3870

E-mail: claimstravelvumi@epicamericas.com

Section I. Information about the **Insured**

1. Policy number: | 2. Last name: | 3. First name: | 4. M.I.:

5. Date of birth: M M / D D / Y Y Y Y | 6. Gender: ◯ Male ◯ Female | 7. Phone number (office or cell): | 8. Fax:

9. Email address: | 10. Address:

11. City: | 12. State: | 13. Zip code: | 14. Country:

Section II. Information about the **Trip**

1. City and country of destination: | 4. Travel period: From M M / D D / Y Y Y Y To M M / D D / Y Y Y Y

Section III. Information about the **Claim**

1. Type of claim:

- ◯ Illness
- ◯ Injury
- ◯ Accident
- ◯ Repatriation of remains
- ◯ Compassionate emergency visit or repatriation
- ◯ Other (*please provide details of the incident including the date*):

2. Provide a brief description of the illness, injury or accident:

IF THE CLAIM IS DUE TO **ILLNESS**, PROVIDE THE INFORMATION BELOW:

1. Date symptoms first appeared: M M / D D / Y Y Y Y | Date of first treatment: M M / D D / Y Y Y Y | 3. Treating physician, clinic or hospital:

4. Were you hospitalized? If yes, please indicate: ◯ Yes ◯ No

4a. For how many days?:

5. Have you experienced similar symptoms before? If yes, please indicate: ◯ Yes ◯ No

5a. When?: M M / D D / Y Y Y Y

6. Do you have any chronic illness or disease? If yes, please indicate: ◯ Yes ◯ No

6a. Date of diagnosis: M M / D D / Y Y Y Y *6b. Diagnosis:*

7. List any medications taken prior to visiting the doctor:

1	
2	
3	
4	
5	

Section III. Information about the **Claim** (continued)

IF THE CLAIM IS DUE TO **INJURY**, PROVIDE THE INFORMATION BELOW:

1. Date of injury: M M / D D / Y Y Y Y

2. Place of injury:

3. Description of injury:

4. Did the injury occur on private property? If yes, please indicate: ◯ Yes ◯ No

4a. Property insurance company name:

4b. Insurance company phone number:

4c. Policy number:

4d. Property owner:

4e. Claim number (if applicable):

IF THE CLAIM IS DUE TO **ACCIDENT**, PROVIDE THE INFORMATION BELOW:

1. Date of accident: M M / D D / Y Y Y Y

2. Place of the accident:

3. Description of accident:

4. Was the incident a motor vehicle accident? If yes, please indicate: ◯ Yes ◯ No

4a. Vehicle insurance company name:

4b. Claim number (if applicable):

4c. Policy number:

4d. Vehicle owner name:

4e. Vehicle owner phone number:

If more than one vehicle was involved, submit a separate sheet with the information on this section for each vehicle. For claims related to accidents, a police report may be required.

IF THE CLAIM IS DUE TO **REPATRIATION OF REMAINS**, PROVIDE THE INFORMATION BELOW:

1. List of expenses *(Include any baggage transportation expenses of the deceased insured's baggage and travel expenses of a summoned relative or fellow traveler, if any)*:

	DATE OF SERVICE	DESCRIPTION OF THE PROCEDURES/SERVICES RECEIVED	AMOUNT BILLED	AMOUNT PAID	CURRENCY
1	M M / D D / Y Y Y Y				
2	M M / D D / Y Y Y Y				
3	M M / D D / Y Y Y Y				
4	M M / D D / Y Y Y Y				

IF THE CLAIM IS DUE TO **COMPASIONATE EMERGENCY VISIT OR REPATRIATION**, PROVIDE THE INFORMATION BELOW:

1. List of expenses *(Arline tickets must be in economy class)*:

	DATE OF SERVICE	DESCRIPTION OF THE SERVICES RECEIVED	AMOUNT BILLED	AMOUNT PAID	CURRENCY
1	M M / D D / Y Y Y Y				
2	M M / D D / Y Y Y Y				
3	M M / D D / Y Y Y Y				
4	M M / D D / Y Y Y Y				

2. Reason for insured's or companion's return trip:

Section IV. Information about the **Insured's Physician**

INSURED'S USUAL **PHYSICIAN** IN HIS/HER COUNTRY OF RESIDENCE

1. Last name:
2. First name:
3. M.I.:
4. Address:
5. City:
6. State:
7. ZIP code:
8. Country:
9. Email address:
10. Phone number:
11. Fax:

INSURED'S USUAL **PHARMACY** IN HIS/HER COUNTRY OF RESIDENCE:

1. Pharmacy name:
2. Address:
3. City:
4. State:
5. ZIP code:
6. Country:
7. Email address:
8. Phone number:
9. Fax:

Section V. Information about the **Services Provided and Claimed Expenses**

	DATE OF SERVICE	DESCRIPTION OF THE PROCEDURES/SERVICES RECEIVED	AMOUNT BILLED	AMOUNT PAID	CURRENCY
1	M M / D D / Y Y Y Y				
2	M M / D D / Y Y Y Y				
3	M M / D D / Y Y Y Y				

Section VI. Other **Payments and Insurance**

1. Do you have benefits available through other insurance? If yes, please indicate: ◯ Yes ◯ No

	NAME OF THE INSURANCE PROVIDER	POLICY NUMBER	TELEPHONE NUMBER
1			
2			
3			

2. Have you claimed benefits from any other party? If yes, attach a copy of the settlement or denial. ◯ Yes ◯ No

2a. If not, please state why:

Section VII. **Reimbursement** Method

◯ Bank transfer

1. Bank name:

2. Bank address:

3. Account holder name:

4. Account number:

5. IBAN for Brazil & Europe, CLABE for Mexico or Swift Code (BIC) for USA:

◯ Check

1. Name:

2. Mailing address:

4. City:

5. State:

6. ZIP code:

7. Country:

If no choice of reimbursement method is selected, a check will be issued and mailed to the address listed in Section I. The reimbursement method cannot be changed once the claim has been processed.

Section VIII. **Certification** and Authorization

I certify that I have read and reviewed all answers and statements in this form and that, to the best of my knowledge, the information is complete and correct. I understand that any omissions, incomplete statements, or incorrect answers may result in the delay or denial of this claim.

I hereby authorize VUMI® or VUMI® Group, its subsidiaries and affiliates to request my medical records and/or those of my dependents or travel companions, as well as any prescription drug history and any other medical or pharmaceutical information to be considered in the claim process for myself, my dependents or travel companions. I authorize any physician, hospital, laboratory, pharmacy or other medical provider, health plan, insurer, the Medical Information Bureau (MIB), or any other organization or person, including any family member who has medical records or knowledge of me or my health to disclose such information, or any other information required to process this claim, to VUMI® or VUMI® Group or its designated representatives. Likewise, I hereby authorize VUMI® or VUMI® Group and its subsidiaries and affiliates to disclose to my agent/insurance agency, affiliates, successors and the Medical Information Bureau (MIB) the terms of my policy, my certificate of coverage and other insurance documents, payment information, claims, reimbursement requests and medical records that may contain protected health information that will enable them to address my questions and facilitate interaction regarding my insurance coverage and claims payments. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

A photocopy of this authorization shall be as valid as the original.

1. Insured's full name (*or parent's/legal guardian's if the insured is a minor*):

2. Insured's signature (*or parent's/legal guardian's if the insured is a minor*):

X.....

3. Date:

M M / D D / Y Y Y Y

VUMI® GROUP
Claims administration services provided by Epic Health Solutions

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