AD&D claim form

Travel Guardian by UnitedHealthcare Global is underwritten by H&W Indemnity SPC for and on behalf of Global Solutions SP. Please complete this form to make a travel insurance claim.

Insured/patient/decedent information

Name of policyholder	Policy number		ID number	
Home address	City	State	Postal code	Country
Name of deceased/patient/relation			Date of birth	
Address (if different)	City	State	Postal code	Country

Claim information

This claim is being made under: (Check one)
☐ Accidental death
☐ Accidental dismemberment

Nature of dismemberment – Loss of: (Check one)

☐ Right hand	☐ Right foot	☐ Sight of right eye
☐ Left hand	☐ Left foot	☐ Sight of left eye
☐ Both hands	☐ Both feet	☐ Sight of both eyes

Date of injury	Date of death

Place where accident happened

Describe how and where accident occurred

IMPORTANT: THIS FORM MUST BE COMPLETED AND RETURNED TO THE COMPANY WITHIN 90 DAYS FROM DATE OF LOSS.

FOR DEATH BENEFITS – A notarized copy of the death certificate must accompany this form. Also, a copy of any policy report along with a copy of the autopsy including toxicology results must accompany this form.

FOR DISMEMBERMENT BENEFITS – A copy of the attached attending physician statement must be completed, signed and accompany this form.

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AUTHORIZATION: By signing below, I agree that UnitedHealthcare Global can collect, use, and process sensitive personal data for individuals covered under this policy as needed in order to administer the policy and ensure that coverage is properly provided. I understand that this consent can be withdrawn at any time; however, if consent is withdrawn or refused, UnitedHealthcare Global may not be able to continue providing services including the payment of claims. I hereby authorize H&W Indemnity SPC for and on behalf of Global Solutions SP or its representative, to inspect or secure copies of medical records, laboratory reports, diagnosis, prognosis, x-rays, and any other data covering this and /or previous conditions, confinements or disabilities. A photo static copy of this authorization and acknowledgment shall be deemed as effective and valid as the original. I ALSO ACKNOWLEDGE THE ATTACHED FRAUD WARNINGS.

Signature of insured	Date
(or) Authorized representative	Date

Statement of attending physician – ADDPH-0517

Patient's name	Date of birth

Nature of injury:

Date of injury

Is the claim made for a loss which from illness, disease, bodily infirmity or any bacterial infection occurring from an accidental cut or wound, rather than from the injury sustained? ☐ Yes ☐ No

Loss of bodily member

If the claim being made due to a loss of member, was the loss due to the injury sustained and not directly or indirectly from any disease or infirmity of mental or bodily nature? ☐ Yes ☐ No

Was an amputation performed at or above the wrist or ankle? ☐ Yes ☐ No

Date performed	☐ Right hand	☐ Left hand	☐ Right foot	☐ Left foot

Loss of vision

If the claim being made is for loss of vision, is the loss of sight recoverable by natural, surgical or artificial means? ☐ Yes ☐ No

Loss of thumb and index finger of same hand

If the claim being made is for loss of thumb and finger of same hand, was there a complete Severance* through or above the metacarpophalangeal joints? ☐ Yes ☐ No

*Severance meaning the complete separation and dismemberment of the part from the body.

If no, please describe the loss

Physician's name and address	City	State	ZIP code
Physician's phone number (include country code)	Fax number	Tax ID	
Signature of physician		Date	

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Mailing instructions

Please complete this claim form and return to:
Attention: Co-Ordinated Benefit Plans, a subsidiary of One80 Intermediaries
On Behalf of H&W Indemnity SPC for and on behalf of Global Solutions SP
P.O. Box 26222
Tampa, FL 33623

OR

Email to: **TGGClaims@cbpinsure.com**
Customer Care: **1-833-610-0736**

Consent to receive all communications electronically

Please be advised, our preferred method of communication with you is electronically by email. Use of email helps us provide better and faster service. Please provide your consent to this in the area below. We will keep this on file with your claim.

Expressed consent to receive all communications electronically:

I agree to receive all mailings and communications electronically

I have read and agree to the **terms and conditions** of the electronic delivery*

I Accept ☐ Yes ☐ No

Please confirm the preferred email address:

Email address _____

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*Click the terms and conditions above to review online, or download a copy by typing the below URL into your internet browser.
http://policydocuments.tpaproducts.com/EDOD/consent.pdf

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Important Notice

Fraud Warning: Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

Notice to District of Columbia Claimants: 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.

Notice to Kentucky Claimants: 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.

Notice to Maine Claimants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Notice to Maryland Claimants: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Minnesota Claimants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Notice to New Hampshire Claimants: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

Notice to New Mexico Claimants: 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.

Notice to Oklahoma Claimants: 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.

Notice to Pennsylvania Claimants: 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.

Notice to West Virginia Claimants: 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 fines and confinement in prison.

Please maintain a copy of this document for your records.

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