

Travel Insured International, Inc.®
Claims Department, P.O. Box 280568, East Hartford, CT 06128
 Phone: 1-866-690-6499 | Fax: 1-860-528-8005
 Email: claims@travelinsured.com | Web: www.travelinsured.com

Please complete the following form with information pertaining to the most recent onset of the illness. Please print clearly.

| | | |
|--|--|-----------------|
| Patient's Name | Planholder | Plan/Policy No. |
| Diagnosis and/or ICD-9 Code | | |
| What is the exact date the symptoms first appeared? | When did the patient first consult you for this condition? | |
| Did you advise the trip be cancelled or interrupted due to the patient's medical condition? ___ Yes ___ No If Yes, Please explain why. | | |
| Has the patient ever had the same or a similar condition? | If Yes, what was the date? | |
| Is this condition a complication of an underlying condition? | List all dates you provided treatment for this condition. | |
| Was this patient referred to you by another physician? ___ Yes ___ No | If Yes, what was the date referred? | |
| Name of Physician | If Yes, what was the date referred? | Phone # |
| If the patient was hospitalized, provide name of hospital | Was this an emergency room admission? ___ Yes ___ No | |
| Date Admitted | Date Discharged | |

Please note: All of the above requested information is necessary for the processing of the planholder's claim. Any omitted items will delay processing.

| | | |
|------------------------|--------------------------|--------------------|
| Physician's Name | Physician's Employer ID# | |
| Physician's Speciality | Phone # () | Fax # () |

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable by law.

I have read the foregoing, and the above answers are true and complete according to the best of my knowledge and belief.

Signature of **Physician**

____/____/____
Date