CareMed®
International Travel Insurance

Claim Form for PAX Participants 2022-2023

Your Personal Data	
Last Name Date of Birth (DD/MM/YY)	First Name
Address in Home Country	**Host Family Address in United States**
Date I will return to my home country: (DD/MM/YY)	c/o Host Family Names
Address	Address
City	City
Province/State	State
Postal Code and Country	ZIP Code
Phone Number	Phone Number
E-Mail Address	E-Mail Address
Your Medical Treatment	
Why did you seek treatment? Was this an illness or an accident? ☐ Illness ☐ Accident	
If illness, have you had it before? ☐ No ☐ Yes **If yes**, when?	
If accident, was it ☐ Your own responsibility ☐ Caused by a third party	
Reimbursement	
Doctor/Hospital Name: Address, City, State:	
Have you already paid the doctor's bill? ☐ No ☐ Yes **If no**, payment will be made directly to the doctor/hospital. **If yes,** preferred method of reimbursement: ☐ Check sent to student at host family address ☐ My host parent paid the bill for me. Please send a check to _____ (host parent name) at the host family address listed above. ☐ Wire transfer to student's home country bank account (student shall pay all bank/wire transfer fees)	
Only complete this section if you selected reimbursement by wire transfer: Bank Name: Bank Address/City/Country: Account Holder Name: Account Number: Bank Code: SWIFT/BIC and IBAN Code:	
Claim Documents and Signature	
Please send completed claim form with documentation and proof of payment (receipts, bills, or invoices) by email, fax, or mail to the claims office indicated below. Incomplete or wrong information will cause payment delay. Please keep copies of all documents submitted. Email: claimhelp@culturalinsurance.com Fax: 203-399-5596 CareMed Claims CISI Claims Department 1 High Ridge Park Stamford, CT 06905	**FINALLY, PLEASE READ AND SIGN:** I hereby authorize any hospital, physician or other person who has attended or examined me, including those in my home country to furnish to the Assistance Center, or its representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical reports. A photostatic copy of this authorization shall be considered as effective and valid as the original. **Student Signature:** **Date:**