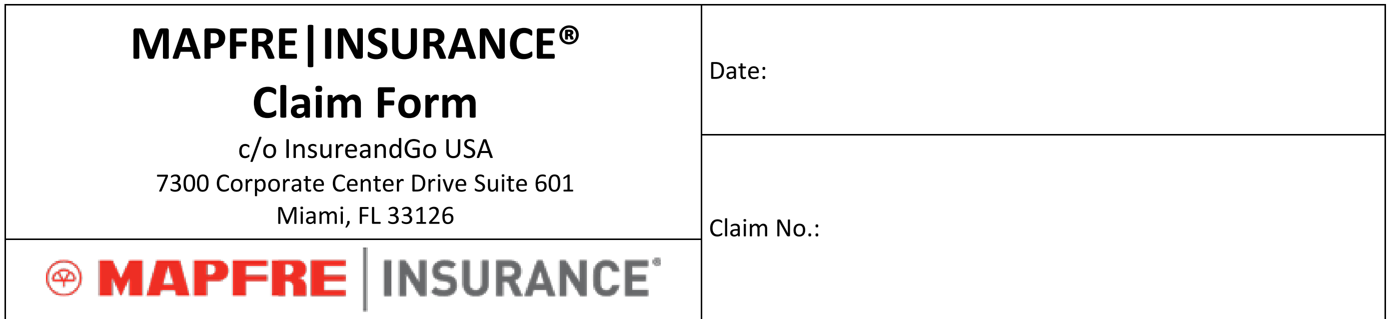


MAPFRE|INSURANCE® **Claim Form** c/o InsureandGo USA 7300 Corporate Center Drive Suite 601 Miami, FL 33126	Date:
MAPFRE | INSURANCE®	Claim No.:

Emergency Medical / Dental Expense					
Name of Insured					
Home Address					
State		**City**		**Zip**	
Home Telephone		**Date Of Birth**			
Cell Phone		**E-mail Address**			
Mailing Address, if different from Home Address:					
Street Address					
State		**City**		**Zip**	
Plan Information/ Trip Information					
Policy #		**Date Incident Occurred**			
Departure Date		**Return Date**			
Original Destination		**Travel Agency Name**			
Date of Initial Deposit/Payment		**Travel Agency Phone #**			
Traveling Companions (Please indicate name and relationship to you**)**					
1.		**6.**			
2.		**7.**			
3.		**8.**			
4.		**9.**			
5.		**10.**			

Health Carrier Coverage Information

In order for us to properly coordinate your Emergency/Medical/Dental benefits with your Health/Dental Insurance, please indicate the name and policy number of your health carrier below.

Health Insurance Carrier		Street Address			
State		City		Zip	
Policy #		Policyholder Name			
If Medicare is your health insurance carrier, please list your HICN#: (this number can be found on your Medicare card)					

If you do not have health insurance, please complete below.

I, ____ , do swear, that I do not have a health insurance policy in effect under my name, nor am I covered by the health insurance policy of anyone else or any group.

Has a claim been submitted to any other party or insurer? If **YES**, please provide details and a claim reference number below.	☐ **YES**	☐ **NO**
Claim Reference Number		

Claim Filing Instructions

- ☐ Original evidence to show dates of departure and return travel (booking invoice, travel tickets, itinerary etc.).
- ☐ All original invoices/receipts for expenses incurred.
- ☐ If a claim is submitted on behalf of the estate of a deceased insured, we will require certified copies of the death certificate, together with Estate Letters of Administration. If the insured passed away due to illness rather than the result of injury, we may require a medical certificate to be completed by the deceased's Primary Care Physician (PCP).
- ☐ If a claim is being submitted as a result of injury, please provide a full description of the incident leading up to the injury, and if another party was involved, please provide their details, including insurance carrier information, if available.

PLEASE SEND DOCUMENTS AND KEEP COPIES FOR YOUR RECORDS

If you are unable to supply any of the documentation requested, please provide a written explanation.

Please Answer All Questions

Date and Time the injury / illness occurred	**Date:**	**Time:**	Country and Town / Province where injury / illness occurred	**Country:**	**Town/Province:**
Full description of illness or injury and details of any other party involved:					

Important – please number all receipts for expenses incurred and write the corresponding number in the column headed 'Receipt No.' when completing the 'Medical Expenses' section below.

Have you previously suffered from the condition which resulted in the submission of this claim, or any related condition? If answer is **YES**, we may require your PCP to complete a medical affidavit.	☐ **YES**	☐ **NO**

Medical Facility					
Date & Time Admitted	**Date:**	**Time:**	**Date & Time Discharged**	**Date:**	**Time:**

Medical Expenses

Receipt No	Date of Service	Description of Service	Service Provider	$ Amount	Paid Y/N

Total	**$**

Other Insurance					
Do you, or anyone else making a claim have any other insurance which may cover this trip? (i.e. Private medical insurance, travel insurance through your credit card, tour operator/travel agent.) If **YES**, please provide full details below:				☐ **YES**	☐ **NO**
Company Name		**Street Address**			
State		**City**		**Zip**	
Group #		**Member ID #**			
Policy #					
Previous Claims					
Have you or any person covered by this policy previously made a claim of this type under any other travel insurance? If **YES**, please provide details below:				☐ **YES**	☐ **NO**

Please proceed to the next page in order to complete Health Conditions Assessment

Health Conditions Assessment		
On the date of travel, purchase of the policy or booking of the trip, were you, or a traveling companion whose condition has given rise to the claim:		
Aware of any medical condition or set of circumstances which could reasonably be expected to give rise to a claim?	☐ **YES**	☐ **NO**
Having an on-going medical condition (or any medical complication directly attributable to that condition) which was being investigated by a specialist or General Practioner? **(If the condition was declared at the time of the policy, please give details below.)**	☐ **YES**	☐ **NO**
Having a medical condition directly or indirectly related to the condition for which the claim is being made? **(If the condition was declared at the time of the policy, please give details below.)**	☐ **YES**	☐ **NO**
Having received or awaiting hospital tests or treatment for any condition or set of symptoms which had not yet been diagnosed?	☐ **YES**	☐ **NO**
Having been given a terminal prognosis?	☐ **YES**	☐ **NO**
Having been travelling for the purpose of obtaining medical treatment abroad?	☐ **YES**	☐ **NO**
Having been travelling against the advice of a medical practitioner?	☐ **YES**	☐ **NO**
Having received or awaiting treatment relating to a complication of pregnancy or childbirth?	☐ **YES**	☐ **NO**
Was a letter concerning any of the above obtained from a treating Physician? If **YES**, please forward a copy of the letter.	☐ **YES**	☐ **NO**
If **YES** was answered to any of the above please give further details of the condition or circumstance. **(Please note that we may need your physician to complete a medical certificate.)**		
Are you expecting to receive, or are you going to submit any further related expenses?	☐ **YES**	☐ **NO**
If **YES**, please provide details (continue on a separate sheet if necessary):		

STATE FRAUD WARNING LANGUAGE

Alabama

"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof."

Alaska

"A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law."

Arizona

"For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

Arkansas

"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."

California

IN GENERAL: "For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

Colorado

"It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies."

Delaware

"Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

District of Columbia

"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." [DC Code]

Florida

"Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree."

Idaho

"Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony."

Indiana

"A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony."

Kentucky

"Any person who knowingly and with intent to defraud any insurance company or other person files a 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."

Louisiana

"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."

Maine

"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 denial of insurance benefits."

Maryland

"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."

Minnesota

"A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

New Hampshire

"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."

New Jersey

"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

New Mexico

"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."

Ohio

"Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

Oklahoma

"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."

Pennsylvania

"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."

Rhode Island

"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 of a crime and may be subject to fines and confinement in prison."

Tennessee

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

Texas

"Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

Virginia

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

Washington

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

West Virginia

"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."

New York

"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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

Insured Signature: ________________________ Date: ______________

AUTHORIZATION	
The undersigned represents and warrants information or documents provided to MAPFRE|INSURANCE® by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief.	
Signature of Claimant 1:	Date:
Signature of Claimant 2:	Date:
Signature of Claimant 3:	Date:
Signature of Claimant 4:	Date:

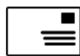
Each person filing a claim must sign and date below.

Signature of Claimant	Date
Signature of Claimant	Date
Signature of Claimant	Date
Signature of Claimant	Date

Return the complete form via email, fax, or mail to:

E-mail: mapfretravelclaims@insureandgousa.com

Fax: (877)570-9801



Mail: MAPFRE|INSURANCE® c/o InsureandGo USA
7300 Corporate Center Dr. Suite 601
Miami, FL 33126

For any questions please contact the below phone number.
Monday – Friday 9:00 AM to 5:00 PM EST

Phone: (888)838-0921

Insurance underwritten by American Commerce Insurance Company Plan administered by Insure & Go Insurance Services USA, Corp