

Non-Medical Expense

Claim Form and Instructions



To complete your claim form, make sure you fill in everything in sections 1–4. And don't forget to sign the form. Instructions for sending the form are on the last page.

1 Claimant Information

Claimant ID *(Please enter the ID number as shown on card)* _____

Claimant's Name *(First name, last name)* _____

Claimant's Date of Birth *(MM/DD/YYYY)* _____ Claimant's Sex Recorded at Birth Male Female

Name of Primary Insured *(First name, last name)* _____

Primary Insured's Date of Birth *(MM/DD/YYYY)* _____

Claimant's Relationship to Primary Insured Self Spouse Child

Employer of Primary Insured _____

Primary Insured's Current Mailing Address _____

Primary Insured or Claimant's Email _____

Primary Insured or Claimant's Phone Number _____

2 Insurance Overview *(See Certificate for all terms and conditions)*

All active participants enrolled in Medical Coverage for Travel: Single Trip Gold or Single Trip Platinum plans are covered (subject to submission of the proper documentation) for the following benefits:

- Emergency Family Travel Arrangements
- Lost Baggage & Personal Effects
- Post-Departure Trip Interruption Transportation
- Post-Departure Trip Interruption Lodging & Incidentals

3 Reimbursement Request *(Check all that apply)*

<input type="checkbox"/> Emergency Family Travel Arrangements	<input type="checkbox"/> Post-Departure Trip Interruption: Transportation
<input type="checkbox"/> Lost Baggage & Personal Effects	<input type="checkbox"/> Lodging & Incidentals

Date of Incident *(MM/DD/YYYY)* _____

Place of Incident _____

Description/Details of Incident *(Attach additional notes if necessary—see back for instructions)*

4 Charges *(List each type of service or provider in the sections below and attach itemized bills for all services)*

Description of Loss *(Hotel rooms, airline tickets, etc.)*

Dates of Service *(MM/DD/YYYY)* _____ Charges *(Please indicate currency)* _____

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5 Signature

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the claimant named above. Authorization is hereby given to any provider of service, that participated in any way in the claimant's care, to release to Blue Cross Blue Shield Global SolutionsSM and its business associates in any country any medical or other personal information that they deem necessary to provide service or adjudicate this claim, recognizing that applicable law concerning personal information may differ among countries. If a person is under 18 years of age, this form must be signed by their parent/guardian/school administrator in the space provided below.

Signature of Primary Insured Member or Claimant _____ Date _____

General Fraud Warning

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.

Third Party Reimbursement

All payments will be made to the Primary Insured if the bills have been paid by you. If you would like a third party to receive reimbursement for covered expenses under this policy, you must request a Third Party Reimbursement Form from Blue Cross Blue Shield Global Solutions Member Services.

Authorization for Third Party Reimbursement is voluntary. Any documentation accompanying a payment or otherwise could contain federal and/or state Protected Health Information and other protected private or financial information. Protected Health Information means health data that could be used to individually identify you including your name, address and specific medical material and facts.

Instructions for Filing a Claim

Please note, incomplete form submissions will delay the processing of your claim(s).

In order to claim the reimbursement available to qualified members, members must include the following documentation with this completed and signed claim form:

For lost baggage (not returned) or personal effects:

- Proof of loss: documentation from the carrier (cruise line, airline, etc.) regarding the filing and disposition of your claim with them, or a police report (required) if theft and loss is not related to a carrier
- An itemized listing of all lost/stolen items and their value
- Original receipts of purchase

For a post-departure trip interruption for a covered reason:

- All unused tickets (airline, cruise line, etc.)
- Proof of payment and receipts for any additional transportation expenses incurred
- Proof of payment and receipts for any additional lodging and incidental expenses incurred (alcohol and tobacco products are not reimbursable)
- A statement from the treating physician specifying the nature of the illness/medical reason why your trip could not be continued
- Documentation of Refunds received from the travel supplier(s) and/or Common Carrier(s)
- Copy of travel supplier's policy which details plan provisions, exclusions and any penalties

For claims related to expenses incurred due to required quarantine/isolation, one of the following is required:

- A statement from the treating physician specifying the nature of the illness/medical reason why your trip could not be continued and the requirement to quarantine/isolate. The statement should include quarantine period.

OR

- Documentation of government's requirement to quarantine/isolate. The documentation should include required quarantine period.

For emergency family travel arrangements:

- Proof of payment and receipts for all transportation expenses incurred
- Proof of payment and receipts for all lodging expenses incurred

Send completed claim forms, written inquiries and address changes to:

Blue Cross Blue Shield Global Solutions

Claims Department

PO Box 1748

Southeastern, PA 19399-1748

Claims Submission Fax: +1 610 482 9623

Claims Submission Email: claims@bcbsglobalsolutions.com

24/7/365 Member Services | Outside the U.S.: +1 610 254 5850 | Inside the U.S.: 855 481 6647