Please detach the below insurance card and keep it always with you

AVI INTERNATIONAL The Travel Insurance

CLAIM FORM
MEDICAL / DENTAL
DAMAGED / STOLEN PROPERTY (Back)

SECTION **1**. PLEASE **PRINT OR TYPE CLEARLY.** This section must be filled out completely for all claims.

First and last name of Insured (list all names you are known by)		☐ Male ☐ Female	Date of Birth
Home Country Address			Phone #
Host Country Address			Phone #
Email address			
Home Country Departure Date	Home Country Return Date	Has previous form been submitted for this claim ? ☐ Yes - Date ☐ No	
Date of sickness / accident Date first saw physician	Were you in a motor vehicle accident ? ☐ No ☐ Yes, Name of driver and address	Have you had any previous treatment for this condition ? ☐ No ☐ Yes, if so when ?	month / year
Are you cured ? ☐ Yes ☐ No	Is there any pending medical invoice we should receive ? ☐ Yes ☐ No	Benefits should be paid to : ☐ Doctor ☐ Hospital ☐ Camp / Exch. Org ☐ Insured ☐ Host family ☐ Other (specify)	
Are you eligible for a National Medical System in your Home country ? ☐ Yes ☐ No	Does any other Insurance company cover this illness or injury ? ☐ No ☐ Yes, Compagny Name, address & policy #	Should you wish a bank transfer, please make sure to provide your complete bank details (bank name, bank address, account n , IBAN and SWIFT codes).	
Describe your illiness or injury. If injury, how did it happen ?			

SECTION **2** : TO BE COMPLETED BY **CLAIMANT** (Participant)**. CLAIM CANNOT BE PROCESSED WITHOUT INSURED SIGNATURE**

MEDICAL REALEASE FORM

I HEREBY CERTIFY that the above statements are true and correct to the best of my knowledge, and further I AUTHORIZE THE INSURANCE COMPAGNY or any party the Company authorizes to obtain, or release any information acquired in the course of my examination or treatment.

I CERTIFY that I will make no claims on lost or damaged property after reimbursement has been paid, should the property later be recovered, and that I will notify the Company immediately should I take possession of said property.

Sign here .....

Participant *Date and Place*

SECTION **3** : TO BE COMPLETED BY **ATTENDING PHYSICIAN**

Diagnosis : .....

Has patient ever had same or similar symptoms ? ☐ No ☐ Yes, if so when & where .....

Is it a congenital condition ? ☐ No ☐ Yes.....

Signature of Physician or Supplier

SECTION **4** : TO BE FILLED OUT BY THE **PARTICIPANT**. Please itemize all the medical charges & expenses as is applicable.
Attach all ORIGINAL (not photocopies) bill and receipts.

DATE OF SERVICE	NAME OF MEDICAL SERVICE PROVIDER/PHARMACIES	CHARGES
.....		.....
.....		.....
.....		.....
.....		.....
	TOTAL MEDICAL AND/OR MEDICATION BILL CLAIM AMOUNT	.....

PROPERTY CLAIM ONLY

PLEASE FILL OUT SECTION # 1, 2, 5, & 6

SECTION **5** : COMPLETE FOR **PERSONAL PROPERTY** (DAMAGED/STOLEN ARTICLES)

What kind of damage/loss ?	When & where did the damage/loss occur ? (yr/mo/day) | Become noticed (yr/mo/day)
Where were you when damage/loss was noticed ?	Has the damage/loss been reported (attach report) ☐ Police ☐ Transport Co. ☐ Area Rep. ☐ School/Hotel
Where were articles kept when damage/loss occured ?	Was the room locked ? ☐ No ☐ Yes; Where was the key
Was the storage place (suitcase, locker, drawer, etc...) locked ? ☐ No ☐ Yes; Where was the key ?	What other step was taken to protect items ?
Describe in detail the circumstances of damage/loss (list damaged/stolen property below, section 6) : .... (Attach separate sheet if necessary)	
Does any other insurance cover this damage/loss ? ☐ **No** ☐ **Yes; Company Name, Address & Policy no.**	

SECTION **6** : COMPLETE FOR **ALL CLAIMS**

☞ Property damage/loss : List below all stolen/damaged property. Include original purchase price or repair cost. Attach original bills and receipt
Replacement invoices will NOT be considered proof of property or proof of value.

Describe property in detail	To be paid to : (attach list if needed)	For Property Claim Only		Amount of Claim
		Purchase Amount or Repair Cost	Date of Purchase	
.....				
.....				
.....				
.....				
.....				
.....				
.....				
(Attach separate sheet if necessary)				

Compensation to be paid to ☐ Insured	☐ Host Family
☐ Someone Else (Full name, Address and reason)	☐ Camp (Full name, Address and reason)