Mailing Address: 1 High Ridge Park, Stamford, CT 06905 | E-mail: claimhelp@mycisi.com | Fax: (203) 399-5596

For claim submission questions, call (203) 399-5130 or e-mail claimhelp@mycisi.com

INSTRUCTIONS:

1. Fully complete and sign the medical claim form for each occurrence, indicating whether the Doctor/Hospital has been paid.
2. Attach itemized bills for all amounts being claimed. *We recommend you provide us with a copy and keep the originals for yourself.
3. Approved reimbursements will be paid to the provider of the service unless otherwise indicated.
4. Submit claim form and attachments via mail, e-mail, or by fax (provided above).

See next page for state specific disclaimers, claimant cooperation provision and additional claim submission instructions.

*** IMPORTANT: If your claim pertains to an Accident, SECTION 2 MUST be completed. If your claim pertains to a Sickness/Illness, SECTION 3 MUST be completed. Failure to complete one of these sections (whichever section pertains to your claim), will cause a delay as we will request for you to complete this form again to include this necessary information in order to process your claim. For claims related to one of the Travel Assistance Benefits, see Section 5.

SECTION 1: NAME AND CONTACT INFORMATION OF THE INSURED

Name of the Insured:___ ____ Date of Birth: _______/____
(month/day/year)

*Please indicate which is your home address: … U.S. Address … Address Abroad

U.S. Address:____
street address apt/unit # city state zip code

Address Abroad: ____

E-mail Address: ____________________________________ Phone Number: ______________________

SECTION 2: IF IN AN ACCIDENT***

Date of Accident:______/______/_______ Place of Accident: ______________________ Date of Doctor/Hospital Visit:_______/________/____

Description/Details of Injury (attach additional notes if necessary):____

____

SECTION 3: IF SICKNESS/ILLNESS***

Description of Sickness/Illness (attach additional notes if necessary) :____

Onset Date of Symptoms: _______/________/_______ Date of Doctor/ Hospital Visit: _______/________/________

Have you had this Sickness/Illness before? … YES … NO If yesf****aOàa_____/___.dnyoo58 ( )]TJ ET q 0 0 612 792 re W n BT 0.149 G 0.214 w /C2_0 1 Tf 0 Tc 0 Tw 2

Instructions f or Claim Submission on Unrelated to a Medical Incident

For residents of Pennsylvania: Any person who knowingly and with the 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.

For cl aiman ts not residing in Alabama, Arkansa s Calif ornia, Color