Claim Form

TO BE COMPLETED BY CARDHOLDER

I-GENERAL NFORMATION

Certificate Number	Passport Number	Effective Date (MM/DD/YYYY)	Termination Date (MM/DD/YYYY)
		/ /	/ /

Client (Cardholder) Full Name:	Name(s) Last Name	Gender [ ] Female [ ] Male	Date of Birth (MM/DD/YYYY) / /
Eligible Dependent Full Name:	Name(s) Last Name	Gender [ ] Female [ ] Male	Date of Birth (MM/DD/YYYY) / /
Address of person submitting the claim:	Street City State Country Zip Code		

Email Address:		Residential Telephone:		Cellular Number:	

II-CLAIM DETAILS

Type of Claim:

[ ] Accident [ ] Disease [ ] Injury [ ] Luggage [ ] Other

Other (Explain): _____

Date of Occurrence (MM/DD/YYYY) / /

Place of Occurrence

Offer details:

Amount Claimed

IN THE EVENT OF A MEDICAL ASSISTANCE CLAIM:

Have you had similar or the same symptoms previously?	[ ] Yes [ ] No
Have you previously received treatment for this condition?	[ ] Yes [ ] No
If affirmative, where and since when?	
Attending physician name:	
Attending physician address:	
Attending physician contact information:	

III- AUTHORIZATION TO RELEASE MEDICAL INFORMATION

As evidence with my signature below, I authorize any licensed physician, medical practitioner, hospital, clinic or any medical establishment or medically related, insurance company, governmental agency, MIB, Inc. ("MIB) or any organization, institution or person having records or knowledge about me or my health and my dependents named on the application to disclose to Redbridge Assist, affiliates and reinsurers such information, including copies of records related to any advice, care or treatment provided to me or my dependents, without any limitation to information related with mental illnesses, use of drugs and/or alcohol.

A photocopy of this authorization shall be as valid as the original.

Client's Signature (Cardholder)	Eligible Dependent Signature (18 years or older)	Date (MM/DD/YYYY) / /