CHP Consolidated Health Plans
A Berkshire Hathaway Company

Travel Medical Insurance Claim Form

Administered by Consolidated Health Plans (CHP)

Submit this claim form (and keep a copy) substantiating each claim immediately after the date of the accident or illness if possible. If available, copies of bills (in English) for initial expenses should be sent with the claim form. Copies of all subsequent bills (in English) should be sent as received. All charges must be substantiated with itemized statements submitted by doctors, hospitals, pharmacies, etc. before a claim can be processed. Billing statements that are not itemized are not acceptable as they do not show the specific services provided. Be sure to sign the claim form and fill in the date before submitting your claim. Make copies for yourself and mail or fax the claim form and all supporting documentation to:

CHP Claims Department
2077 Roosevelt Avenue
Springfield, MA 01104-0420
Fax: 1-413-733-4612

Questions? If you have any questions about your insurance benefits, please call CHP from within the United States at 1-800-633-7867 or outside the United States, call 001-413-733-4540 and choose Option 5. You can also email CHP at customerservice@consolidatedhealthplan.com

Name of Participant _____

ID Number from CHP Insurance Card _____ Host country email address _____

Name of parent or guardian if participant is under 21_____

USA home address _____

USA home phone or cell phone_____ USA home email address_____

Date of accident or sickness_____ Body part (left or right)_____

If sickness, have you had it before? _____Yes _____No; If yes, when and date of last medical treatment_____

Name of Country in which accident or sickness occurred_____

Please indicate who the reimbursement check should be sent to : (note checks can be made payable to the Plan Sponsor or Participant Only). If the program sponsor is submitting for reimbursement please attach a W-9.

Program Sponsor or Participant Name:_____

Address:_____City_____Zip_____

INFORMATION AUTHORIZATION: I hereby authorize any hospital, physician, or other person who has attended me or examined me, to furnish to Nationwide Mutual Insurance Company or its administrator CHP, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature (Required) _____ Date (Required) _____