World Class Coverage Plan

designed for

Colgate University

Off-Campus Study

CISI
CULTURAL INSURANCE SERVICES INTERNATIONAL

2023-2024

Policy # GLM N19005926-COLGATE

Administered by Cultural Insurance Services International

Underwritten by ACE American Insurance Company

MEDICAL EMERGENCY SECURITY

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Insurance described is marketed by Cultural Insurance Services International (CISI); insurance is underwritten and provided by ACE American Insurance Company and its U.S. based Chubb underwriting company affiliates. Chubb is the marketing name used to refer to subsidiaries of Chubb Limited providing insurance and related services. For a list of these subsidiaries, please visit our website at www.chubb.com.

CONTACT INFORMATION

CISI Claims Department (9-5 EST, M-F):

Phone: (800) 303-8120 (toll-free) | (203) 399-5130

Email: claimhelp@mycisi.com

Team Assist (24/7/365) – AXA Assistance:

Phone: (855) 327-1411 | (312) 935-1703

Email: medassist-usa@axa-assistance.us

FAQS (FREQUENTLY ASKED QUESTONS)

Questions related to COVID-19?

Visit our COVID-19 FAQ webpage:
https://www.culturalinsurance.com/COVID-questions.asp

What does the CISI plan cover?

The CISI Plan is designed specifically for cultural exchange participants. Not only does the plan provide accident and sickness insurance, it also covers medical evacuation and repatriation as well as security evacuations should they become necessary. And unlike many domestic insurance plans, the CISI plan will pay 100% of covered expenses without requiring a deductible.

In addition to the above, the Team Assist Plan was designed by CISI in conjunction with the Assistance Company to provide travelers with a worldwide, 24-hour emergency telephone assistance service. Multilingual help and advice may be furnished for the insured in the event of any emergency during the term of coverage. Please read the attached brochure for detailed information regarding benefits.

How will I receive my insurance information?

Once you are enrolled, you will receive an email from CISI Enrollments (enrollments@culturalinsurance.com), with the subject line '**CISI Materials**'. This email will contain the following:

- Brochure
- Consulate Letter (to obtain your visa, if necessary)
- ID Card
- Claim Form
- Link to create a login to our myCISI Participant Portal
- Link to our CISI Traveler App

How do I use my CISI insurance overseas?

In the case of a MINOR injury or illness - Be prepared to pay for doctor visits for minor illnesses such as a sore throat or a sinus infection. Present your card to your medical provider at the time of service. If the overseas doctor is willing to bill us directly, we are willing and able to pay them directly for covered medical expenses. Foreign providers can contact your assistance team (**AXA Assistance**) toll-free to verify eligibility and/or benefits 24/7/365. If they prefer to have you pay for any medical services, medicines, or equipment out-of-pocket at the time of your visit, hold onto all documents, bills and receipts, and submit them along with a claim form to CISI for reimbursement.

In the case of a SERIOUS injury or illness - For all emergencies, seek help without delay at the nearest facility and then, after admittance, open up a case with AXA Assistance (our 24/7 assistance provider). Our goal is to have the hospital or facility bill us directly. If personal payment has already been processed, we can expedite reimbursement. CISI has the ability to pay by check or wire transfer to foreign hospitals when necessary/requested. **AXA Assistance** is also able to guarantee/make payments when necessary (CISI then reimburses **AXA Assistance**).

How do I locate a medical provider and/or hospital?

To locate a provider overseas, you can do either of the following: 1) Contact the **assistance team** (**AXA Assistance**) by calling the number on you insurance ID card (also provided on this page); OR 2) log into your **myCISI Participant Portal** or through the **CISI Traveler App** and click on '**Provider Search**'. Select your Country and City, and a list of providers will populate.

Are there 'In-Network' or 'Out-of-Network' restrictions?

No, you can seek treatment at any medical facility abroad. There are no In-Network nor Out-of-Network restrictions.

Does my plan have a Deductible?

See your plans *Schedule of Benefits* to see if you have a Deductible.

How do I submit a claim & what needs to be submitted?

If you seek medical treatment for an Injury or Illness while abroad and pay out-of-pocket, you are eligible to submit a claim. Claims should be submitted for processing as soon as possible (and no later than one year after treatment was received, if possible).

Step 1: Fully complete and sign the medical claim form for each occurrence, indicating whether the Doctor/Hospital has been paid.
Step 2: Attach itemized bills for all amounts being claimed and documentation. *We recommend you provide us with a copy and keep the originals for yourself.
Step 3: You can submit claims by mail: 1 High Ridge Park, Stamford, CT 06905, email: claimhelp@mycisi.com, or by fax: (203) 399-5596.

Approved reimbursements will be paid to the provider of the service unless otherwise indicated on the form. For claim submission questions or status, call (800) 303-8120, or email claimhelp@mycisi.com.

How long will it take to be reimbursed for medical expenses paid out-of-pocket?

Turnaround for claim payments is generally 15 business days from receipt date. To check the status of your claim, contact CISI at (800) 303-8120 from 9AM to 5PM EST.

Where can I access additional claim forms?

The claim form is provided at the end of your brochure,(the end of this document), attached to your welcome email, and on the **myCISI Participant Portal**.

I misplaced my medical ID card. What should I do?

If you have the CISI Traveler App, your card and information is in the palm-of-your-hand. Within the CISI Traveler App you can access your ID card and download it to your phone so you have access to it even when you are offline. You can also reprint it from your welcome email; or sign into your myCISI Participant Portal and access it there. Another option is to contact CISI by calling (800) 303-8120 or email claimhelp@mycisi.com or enrollments@mycisi.com and we can easily email you with a new ID card within a few minutes.

Have additional questions, or questions related to benefits?

Email claimhelp@mycisi.com or call (203) 399-5130 or toll-free at (800) 303-8120.

Team Assist Plan (TAP)

The Team Assist Plan is designed by CISI in conjunction with the Assistance Company to provide travelers with a worldwide, 24-hour emergency telephone assistance service. Multilingual help and advice may be furnished for the Insured in the event of any emergency during the term of coverage. The Team Assist Plan complements the insurance benefits provided by the Accident and Sickness Policy. If you require Team Assist assistance, your ID number is your policy number. In the U.S., call 1 (855) 327-1411, worldwide call (01 312) 935-1703 (collect calls accepted) or e-mail medassist-usa@axa-assistance.us.

Emergency Medical Transportation Services

The Team Assist Plan provides services and pays expenses up to the amount shown in the *Schedule of Benefits* for:

- Emergency Medical Evacuation
- Repatriation of Mortal Remains

All services must be arranged through the Assistance Provider.

The TAP Offers These Services

(These services are not insured benefits):

MEDICAL ASSISTANCE

Medical Referral: Referrals will be provided for doctors, hospitals, clinics or any other medical service provider requested by the Insured. Service is available 24 hours a day, worldwide.

Medical Monitoring: In the event the Insured is admitted to a foreign hospital, the AP will coordinate communication between the Insured's own doctor and the attending medical doctor or doctors. The AP will monitor the Insured's progress and update the family or the insurance company accordingly.

Prescription Drug Replacement/Shipment: Assistance will be provided in replacing lost, misplaced, or forgotten medication by locating a supplier of the same medication or by arranging for shipment of the medication as soon as possible.

Emergency Message Transmittal: The AP will forward an emergency message to and from a family member, friend or medical provider.

Coverage Verification/Payment Assistance for Medical Expenses: The AP will provide verification of the Insured's medical insurance coverage when necessary to gain admittance to foreign hospitals, and if requested, and approved by the Insured's insurance company, or with adequate credit guarantees as determined by the Insured, provide a guarantee of payment to the treating facility.

TRAVEL ASSISTANCE

Obtaining Emergency Cash: The AP will advise how to obtain or to send emergency funds world-wide.

Traveler Check Replacement Assistance: The AP will assist in obtaining replacements for lost or stolen traveler checks from any company, i.e., Visa, Master Card, Cooks, American Express, etc., worldwide.

Lost/Delayed Luggage Tracing: The AP will assist the Insured whose baggage is lost, stolen or delayed while traveling on a common carrier. The AP will advise the Insured of the proper reporting procedures and will help travelers maintain contact with the appropriate companies or authorities to help resolve the problem.

Replacement of Lost or Stolen Airline Ticket: One telephone call to the provided 800 number will activate the AP's staff in obtaining a replacement ticket.

TECHNICAL ASSISTANCE

Credit Card/Passport/Important Document Replacement: The AP will assist in the replacement of any lost or stolen important document such as a credit card, passport, visa, medical record, etc. and have the documents delivered or picked up at the nearest embassy or consulate.

Locating Legal Services: The AP will help the Insured contact a local attorney or the appropriate consular officer when an Insured is arrested or detained, is in an automobile accident, or otherwise needs legal help. The AP will maintain communications with the Insured, family, and business associates until legal counsel has been retained by or for the Insured.

Assistance in Posting Bond/Bail: The AP will arrange for the bail bondsman to contact the Insured or to visit at the jail if incarcerated.

Worldwide Inoculation Information: Information will be provided if requested by an Insured for all required inoculations relative to the area of the world being visited as well as any other pertinent medical information.

Colgate University

Policy # GLM N19005926-COLGATE

2023-2024

Administered by Cultural Insurance Services International • 1 High Ridge Park • Stamford, CT 06905-1322
This plan is underwritten by ACE American Insurance Company

SCHEDULE OF BENEFITS	
Coverage and Services	**Maximum Limits**
TRAVEL ACCIDENT INDEMNITY INSURANCE	
Accidental Death and Dismemberment Per Insured	$15,000
ACCIDENT AND SICKNESS INSURANCE	
Medical expenses (per Covered Accident or Sickness):	
Deductible	zero
Benefit Maximum	$250,000 at 100%
Extension of Benefits	30 days
TRAVEL ASSISTANCE INSURANCE	
Emergency Reunion	(incl. hotel/meals, max $250/day) $10,000
Trip Cancellation and Interruption	$5,000
PERSONAL PROPERTY INSURANCE	
Baggage Delay	($100/item) $500
Lost Baggage	$1,000
EVACUATION AND REPATRIATION INSURANCE	
Emergency Medical Evacuation	$100,000
Repatriation of Remains	$100,000
Security Evacuation	$100,000
NON-INSURANCE SERVICES	
Team Assist Plan (TAP): 24/7 medical, travel, technical assistance	

Policy terms and conditions are briefly outlined in this Description of Coverage. Complete provisions pertaining to this insurance are contained in the Policy under form number AH-40517-NY. In the event of any conflict between this Description of Coverage and the Policy, the Policy will govern.

Eligibility and Provisions

Benefits are payable under the Policy for Covered Expenses incurred by an Insured for the items stated in the *Schedule of Benefits*. All students and accompanying faculty and staff who are enrolled as participants, and who are temporarily pursuing educational activities outside of the United States and their Home Country are eligible for coverage. Benefits shall be payable to either the Insured or the Service Provider for Covered Expenses incurred Worldwide, except in the United States or their Home Country. The

first such expense must be incurred by an Insured within 30 days after the date of the Covered Accident or commencement of the Sickness; and

- All expenses must be incurred by the Insured within 180 days from the date of the Covered Accident or commencement of the Sickness; and
- The Insured must remain continuously insured under the Policy for the duration of the treatment.

The charges enumerated herein shall in no event include any amount of such charges which are in excess of Reasonable and Customary charges. If the charge incurred is in excess of such average charge such excess amount shall not be recognized as a Covered Expense. All charges shall be deemed to be incurred on the date such services or supplies, which give rise to the expense or charge, are rendered or obtained.

Accidental Death and Dismemberment Benefit

Accidental Death Benefit. If Injury to the Insured results in death within 365 days of the date of the Covered Accident that caused the Injury, We will pay 100% of the Benefit Amount.

Accidental Dismemberment Benefit. If Injury to the Insured results, within 365 days of the date of the Covered Accident that caused the Injury, in any one of the Losses specified below, We will pay the percentage of the Benefit Amount shown below for that Loss:

For Loss of:	Percentage of Maximum Amount:
Life	100%
Two or more Members	100%
Quadriplegia	100%
One Member	50%
Hemiplegia	50%
Paraplegia	50%
Thumb and Index Finger of the Same Hand	25%
Uniplegia	25%

"Quadriplegia" means total Paralysis of both upper and lower limbs. "Hemiplegia" means total Paralysis of the upper and lower limbs on one side of the body. "Uniplegia" means total Paralysis of one lower limb or one upper limb. "Paraplegia" means total Paralysis of both lower limbs or both upper limbs. "Paralysis" means total loss of use. A Doctor must determine the loss of use to be complete and not reversible at the time the claim is submitted. "Member" means Loss of Hand or Foot, Loss of Sight, Loss of Speech and Loss of Hearing. "Loss of Hand or Foot" means complete Severance through or above the wrist or ankle joint. "Loss of Sight" means the total, permanent Loss of Sight of one eye. "Loss of Speech" means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means. "Loss of Hearing" means total and permanent Loss of Hearing in both ears that is irrecoverable and cannot be corrected by any means. "Loss of a Thumb and Index Finger of the Same Hand" means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand). "Severance" means the complete separation and dismemberment of the part from the body. If more than one Loss is sustained by an Insured as a result of the same Covered Accident, only one amount, the largest, will be paid.

Accident and Sickness Medical Expenses

We will pay Covered Expenses due to Accident or Sickness only, as per the limits stated in the *Schedule of Benefits*. Coverage is limited to Covered Expenses incurred as listed below and subject to Exclusions. Initial treatment of an Injury or Sickness must occur within 30 days of the Accident or onset of the Sickness.

When a Covered Injury or Sickness is incurred by the Insured We will pay Usual and Customary medical expenses incurred shown in the *Schedule of Benefits*. In no event shall Our maximum liability exceed the Benefit Maximum stated in the *Schedule of Benefits* as to Covered Expenses during any one period of individual coverage.

Covered Accident & Sickness Medical Expenses

Only such Medically Necessary expenses, incurred as the result of a covered Accident or Sickness, which are specifically enumerated in the following list of charges, and which are not excluded in the Exclusions section, shall be considered as Covered Expenses:

- Hospital semi-private room and board (or room and board in an intensive care unit).

- Hospital ancillary services (including, but not limited to, use of the operating room or emergency room).
- Services of a Doctor or a registered nurse (R.N.).
- Ambulance service to or from a Hospital.
- Laboratory tests.
- Radiological procedures.
- Anesthetics and their administration.
- Blood, blood products, artificial blood products, and the transfusion thereof.
- Physiotherapy.
- Chiropractic and therapeutic expenses on an inpatient or outpatient basis, $50 per visit maximum, up to $500.
- Medicines or drugs administered by a Doctor or that can be obtained only with a Doctor's written prescription.
- Dental charges for Injury to sound, natural teeth up to $500 ($250 maximum per tooth).
- Emergency medical treatment of pregnancy.
- Artificial limbs or eyes (not including replacement of these items).
- Casts, splints, trusses, crutches, and braces (not including replacement of these items or dental braces).
- Oxygen or rental equipment for administration of oxygen.
- Rental of a wheelchair or hospital-type bed.
- Rental of mechanical equipment for treatment of respiratory paralysis.
- Nervous or Mental Disorders are payable a) up to $5,000, 10-visit maximum, for outpatient treatment; or b) up to $10,000, 30-day maximum, on an inpatient basis. We shall not be liable for more than one such inpatient or outpatient occurrence under the Policy with respect to any one Insured.
- Pre-Existing Condition are limited to $10,000.

New York Mandated Benefits: We will comply with the New York mandated benefits and will not deny coverage if a proper claim is submitted for a Covered Accident or Sickness under this Policy.

Extension of Benefits

We will extend benefits under this Policy for 30 days after an Insured's coverage would otherwise end, if on that date the Insured is:

1. Hospital confined for an Injury covered by this Policy; and
2. under a Doctor's care.

Any benefits payable under this provision will not exceed the benefit maximums shown in the *Schedule of Benefits*. However, in no event will this Extension of Benefits allow the coverage period of this Policy to exceed 6 months.

Emergency Reunion

We will pay up to the Benefit Maximum as shown in the *Schedule of Benefits* for expenses incurred to have an Insured's Immediate Family Member accompany him or her to the Insured's Home Country or the Hospital where the Insured is confined if the Insured is confined in a Hospital for at least 24 consecutive hours due to a covered Injury or Sickness and the attending Doctor believes it would be beneficial for the Insured to have an Immediate Family Member at his or her side. The Immediate Family Member's travel must take place within 7 days of the date the Insured is confined in the Hospital.

Covered expenses include an economy airline ticket and other travel related expenses not to exceed the Daily Benefit Maximum and the Maximum Number of Days shown in the *Schedule of Benefits*.

All transportation and lodging arrangements must be made by the most direct and economical route and conveyance possible and may not exceed the usual level of charges for similar transportation or lodging in the locality where the expense is incurred. Benefits will not be payable unless We (or Our authorized assistance provider) authorize in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Our assistance provider.

Trip Cancellation and Interruption Benefit

We will reimburse the Insured for the amount of non-refundable money he or she paid for his or her Trip, up to the Benefit Maximum shown in the *Schedule of Benefits*, if the Insured is prevented from taking his or her Trip or his or her Trip is interrupted as the result of Injury, Sickness or death that occurs prior to the Trip, or during the Trip to either the Insured or an Immediate Family Member.

Baggage Delay Benefit

If the Insured's checked-in luggage is not delivered to him or her within the Time Period shown in the *Schedule of Benefits* at the scheduled destination point of his or her flight, we will reimburse the Insured for charges incurred at the scheduled destination for purchases of essential clothing and toiletries up to the Benefit Maximum shown in the *Schedule of Benefits*. These purchases must be made within 24 hours of the Insured's arrival or prior to the return of the luggage, whichever is sooner.

The Insured must provide documentation of the delay or misdirection of baggage by the Common Carrier and receipts for the emergency purchases.

This does not apply if baggage is delayed after the Insured has reached his or her return destination. We will also pay the reasonable cost to return the Insured's baggage to his or her Home, up to the Insured's limit of coverage.

If the Insured's baggage is delayed for more than 24 hours after his or her arrival at his or her Destination, the Insured will receive a voucher for the equivalent of $100 for the cost of necessary personal effects.

Limitation: This benefit is limited to $100 per day/per Insured up to the Maximum Limit shown in the *Schedule of Benefits.*

Lost Baggage Benefit

We will reimburse the Insured's replacement costs of clothes and personal hygiene items, up to the Benefit Maximum shown in the *Schedule of Benefits*, if the Insured's luggage is checked onto a common carrier, and is then lost, stolen, or damaged beyond his or her use. Replacement costs are calculated on the basis of the depreciated standard for the specific personal item claimed and its average usable period. The Insured must file a formal claim with the transportation provider and provide Us with copies of all claim forms and proof that the transportation provider has paid the Insured its normal reimbursement for the lost, stolen, or damaged luggage.

Emergency Medical Evacuation Benefit

We will pay Emergency Medical Evacuation Benefits as shown in the *Schedule of Benefits* for expenses incurred for the medical evacuation of an Insured. Benefits are payable, if the Insured is traveling outside of his or her Home Country; is traveling outside of 100 miles away from home; suffers a Medical Emergency during the course of the Trip; and requires Emergency Medical Evacuation.

In the event the Insured has been confined in a Hospital for at least 7 consecutive days due to a covered Injury or Sickness and following an Emergency Medical Evacuation, where the attending Doctor believes it would be beneficial for the Insured to have a person chosen by the Insured at his or her side, We will pay the expenses incurred for travel and lodging for that person, up to the cost of round-trip economy airfare.

Benefits will not be payable unless:

- the Doctor ordering the Emergency Medical Evacuation certifies the severity of the Insured's Medical Emergency requires an Emergency Medical Evacuation;
- all transportation arrangements made for the Emergency Medical Evacuation are by the most direct and economical conveyance and route possible;
- the charges incurred are essential for the diagnosis, treatment or care of the Injury or Sickness as determined by the treating Doctor and do not exceed the usual level of charges for similar transportation, treatment, services or supplies in the locality where the expense is incurred; and
- do not include charges that would not have been made if there were no insurance.

An Emergency Medical Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such transportation.

Benefits will not be payable unless the Assistance Company authorizes in advance, and services are rendered by the Assistance Company.

Repatriation of Remains Benefit

We will pay Repatriation of Remains Benefits as shown in the *Schedule of Benefits* for preparation and return of an Insured's body to his or her Home Country if he or she dies due to an Injury or Sickness. Covered Expenses include, but are not limited to:

1. expenses for embalming or cremation;
2. the least costly coffin or receptacle adequate for transporting the remains;
3. transporting the remains by the most direct and least costly conveyance and route possible.

Benefits will not be payable unless the Assistance Company authorizes in advance, and services are rendered by the Assistance Company.

Note: All Covered Expenses in connection with either **Emergency Medical Evacuation** or **Repatriation of Remains** must be pre-approved and authorized by an Assistance Company representative appointed by the Company.

Exclusions and Limitations

We will not pay benefits for any loss or Injury that is caused by, or results from:

- aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.
- participation in a riot or insurrection.
- intentionally self-inflicted injury; suicide or attempted suicide (applicable to Accidental Death and Dismemberment benefits only).
- war or any act of war, whether declared or not.
- commission of, or attempt to commit, a felony or to which a contributing cause was the Insured's being engaged in an illegal occupation.

In addition to the exclusions above, We will not pay Medical Expense Benefits for any loss, treatment or services resulting from or contributed to by:

- routine dental care and treatment. This does not include dental care or treatment necessary due to Injury to sound natural teeth due to a Covered Accident.
- cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
- Mental and emotional disorders in excess of the benefits provided in the Medical Expense Benefit.
- eyeglasses, hearing aids, and examination for the prescription or fitting thereof.
- treatment by any Immediate Family Member.
- treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid).
- custodial care.
- benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable.
- benefits provided under any state or Federal workers; compensation, employers' liability or occupational disease law.
- Pre-Existing Conditions in excess of the Maximum shown in the Benefit Schedule.
- Injury resulting from the following extra-hazardous activities: aviation and related activities, such as skydiving and parachuting, and participation as a professional in athletics or sports.
- foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.
- Services rendered and separately billed by employees of hospitals, laboratories or other institutions.
- services for which no charge is normally made.
- normal pregnancy, other than complications of pregnancy, of the Insured.

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims.

Subrogation

The following Subrogation provision applies only to Accidental Death and Dismemberment Benefit, Emergency Medical Evacuation Benefit, Emergency Reunion Benefit, Medical Expense Benefit and Repatriation of Remains Benefit:

In the event that the Insured suffers an Injury or Sickness for which another party may be responsible, such as someone injuring the Insured in an accident, and We pay benefits as a result of that Injury or Sickness, We will be subrogated and succeed to the right of recovery against the party responsible for the Insured's Sickness or Injury to the extent of the benefits We have paid. This means that We have the right independently of the Insured to proceed against the party responsible for the Insured's Injury or Sickness to recover the benefits We have paid. Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. When entering into a settlement, it ispresumed that the Insured did not take any action against Our rights or violate any contract between the Insured and Us. The settlement between the Insured and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

The following provision applies only to Baggage Delay Benefit, Lost Baggage Benefit, and Trip Cancellation and Interruption Benefit:

To the extent the Company pays for a loss suffered by an Insured, We will take over the rights and remedies the Insured had relating to the loss. This is known as subrogation. The Insured must help Us preserve Our rights against those responsible for the Insured's loss. This may involve signing any papers and taking any other steps We may reasonably require. IfWe take over an Insured's rights, the Insured must sign an appropriate subrogation form supplied by Us.

As a condition to receiving the applicable benefits listed above, as they pertain to this Subrogation provision, the Insured agrees, except as may be limited or prohibited by applicablelaw, to reimburse the Company for any such benefits paid to or on behalf of the Insured, if such benefits are recovered, in any form, from any Third Party or Coverage.

We will not pay or be responsible, without Our written consent, for any fees or costs associated with the pursuit of a claim, cause of action or right by or on behalf of an Insured or such other person against any Third Party or Coverage.

Coverage as used in this Subrogation section, means no fault motorist coverage, uninsured motorist coverage, underinsured motorist coverage, or any other fund or insurance policy except coverage provided under this Policy and any fund or insurance policy providing the Insured with coverage for any claims, causes of action or rights the Insured may have against the Company.

Third Party as used in this Subrogation section, means any person, corporation or other entity (except the Insured and the Company).

Definitions

Company shall be ACE American Insurance Company.

Covered Accident means an accident that occurs while coverage is in force for an Insured and results directly and independently of all other causes in a loss or Injury covered by this Policy for which benefits are payable.

Covered Expenses means expenses actually incurred by or on behalf of an Insured for services covered by this Policy. A Covered Expense is deemed to be incurred on the date such service or supply, that gave rise to the expense or the charge, was rendered or obtained.

Covered Loss or **Covered Losses** means an accidental death, dismemberment or other Injury covered under this Policy.

Deductible means the dollar amount of Covered Expenses that must be incurred as an outof- pocket expense by the Insured on a per Covered Accident or Sickness basis before Medical Expense Benefits and any other Additional Benefits paid on an expense incurred basis, are payable under this Policy.

Doctor means a licensed health care provider acting within the scope of his or her license. It will not include an Insured or an Insured's Immediate Family Member.

Emergency Medical Evacuation means the Insured's: 1) immediate transportation from the place where he/she suffer an Injury or Emergency Sickness to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained; or 2) transportation to his/her Home Country to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury or an Emergency Sickness.

Emergency Sickness means a sickness of such a nature that failure to get immediate medical care could put the person's life in danger or cause serious harm to the person's bodily functions.

Immediate Family Member means a person who is related to the Insured in any of the following ways: spouse; parent (includes stepparent); child age 18 or older (includes legally adopted and step child); brother or sister (includes stepbrother or stepsister); parent-in-law; son or daughter–in–law; and brother or sister-in-law.

Home Country means a country from which the Insured holds a passport. If the Insured holds passports from more than one country, his or her Home Country will be that country which the Insured has declared to Us in writing as his or her Home Country.

Hospital means a short-term, acute, general hospital, which: 1) is primarily engaged in providing, by or under the continuous supervision of Doctors, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons; 2) has organized departments of medicine and major surgery; 3) has a requirement that every patient must be under the care of a Doctor or dentist; 4) provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.); 5) if located in New York state, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97 (42 USCA 1395x(k); 6) is duly licensed by the agency responsible for licensing such hospitals; and 7) is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.

Injury means accidental bodily harm sustained by an Insured that results directly and independently from all other causes from a Covered Accident. The Injury must be caused solely through accidental means. All injuries sustained by one person in any one Covered Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

Insured(s) means the person who applies for coverage and pays the required premium.

Medically Necessary means services and supplies received while insured that are determined by Us to be: 1) appropriate and necessary for the symptoms, diagnosis, or direct care and treatment of the Insured's medical conditions; 2) within the standards the organized medical community deems good medical practice for the Insured's condition; 3) not primarily for the convenience of the Insured, the Insured's Doctor or another service provider or person; 4) not experimental/investigational or unproven, as recognized by the organized medical community, or which are used for any type of research program or protocol; and 5) not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment.

Mental and Nervous Disorder means neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Pre-Existing Condition means an illness, disease or other condition of the Insured, that in the 180-day period before the Insured's coverage became effective under this Policy: 1) first manifested itself, worsened, became acute or exhibited symptoms that would have caused a reasonable person to seek diagnosis, care or treatment; or 2) required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or 3) was treated by a Doctor or treatment had been recommended by a Doctor.

Usual and Customary means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

Sickness means an illness, disease or condition of the Insured that causes a loss for which an Insured incurs medical expenses while covered under this Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

We, Our, Us means the insurance company underwriting this insurance.

IMPORTANT NOTICE

This policy provides travel insurance benefits for individuals traveling outside of their home country. This policy does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy a person's individual obligation to secure the requirement of minimum essential coverage under the Affordable Care Act (ACA). For more information about the ACA, please refer to www.HealthCare.gov

This information provides a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the policy issued in the state in which the policy was delivered under form number AH-15090. Complete details may be found in the policy on file at your school's office. The policy is subject to the laws of the state in which it was issued. Please keep this information as a reference.

Security Evacuation Benefit

If, as a result of an Occurrence that takes place during an Insured's Trip and while traveling outside his or her Home Country, an Insured requires a Security Evacuation, We will pay a benefit to Transport the Insured to the Nearest Place of Safety. The determination that an Insured requires a Security Evacuation must be made by a Designated Security Consultant and all arrangements must be made by Our assistance provider.

Security Evacuation benefits are payable only once per Occurrence during the Insured's Trip.

Benefits will also be payable for Transportation and Related Costs within 14 days of the Security Evacuation to one of these locations:

1. back to the Host Country if return is safe and permitted; or
2. to the Insured's Home Country; or
3. to the Insured's return destination or point of origin for the Trip.

This benefit is subject to the overall Benefit Maximum shown in the *Schedule of Benefits*.
Benefits will be payable for consulting services by Designated Security Consultant for seeking information on Missing Person or kidnapping cases if the Insured is deemed kidnapped or a Missing Person by local or international authorities. This benefit is subject to the overall Maximum Limit shown in the *Schedule of Benefits*.
Our assistance provider must make all arrangements and must authorize all expenses in advance of any benefits being payable. Our assistance provider is not responsible for the availability of Transport services. Where a Security Evacuation becomes impractical because of hostile or dangerous conditions, a Designated Security Consultant will endeavor to maintain contact with the Insured until a Security Evacuation becomes viable.

Definitions

Advisory, as used in this Rider, means a formal travel advisory or recommendation by the United States Government recommending that the Insured or citizens of his or her Home Country or citizens of the Host Country leave the Host Country.
Appropriate Authority(ies), as used in this Rider, means the government authority(ies) in the Insured's Home Country or the government authority(ies) of the Host Country.
Designated Security Consultant, as used in this Rider, means an employee of a security firm under contract with Us or Our assistance provider who is experienced in security and measures necessary to ensure the safety of the Insured(s) in his or her care.
Excluded Country, as used in this Rider, means the following countries from which Security Evacuations are not available under this Benefit: Afghanistan, Iraq, Libya, Somalia, Syria or any country subject to the administration and enforcement of U.S. economic embargoes and trade sanctions by the OFFICE OF FOREIGN ASSETS CONTROL (OFAC).
Host Country, as used in this Rider, means any country, other than an Excluded Country, in which an Insured is traveling while covered under the Policy.
Imminent Physical Danger, as used in this Rider, means the Insured is subject to possible physical injury or sickness that could result in grave physical harm or death.
Missing Person, as used in this Rider, means an Insured who disappeared for an unknown reason and whose disappearance was reported to the Appropriate Authority (ies).
Natural Disaster, as used in this Rider, means a storm (wind, rain, snow, sleet, hail, lightning, dust or sand), earthquake, flood, volcanic eruption, wildfire or other similar event that: a) is due to natural causes; and b) results in such severe and widespread damage that the area of damage is officially declared a disaster area by the government of the Host Country and the area is deemed to be Uninhabitable or dangerous.
Nearest Place of Safety, as used in this Rider, means a location determined by the Designated Security Consultant where: a) the Insured can be presumed safe from the Occurrence that precipitated the Insured's Security Evacuation; and b) the Insured has access to transportation to his or her Home Country; and c) the Insured has the availability of temporary lodging, if needed.
Occurrence, as used in this Rider, means any of the following situations in which an Insured finds himself or herself while covered by the Policy: a) expulsion from a Host Country or being declared persona non-grata on the written authority of the recognized government of a Host Country; b) political or military events involving a Host Country, if the Appropriate Authorities issue an Advisory stating that citizens of the Insured's Home Country or citizens of the Host Country should leave the Host Country; c) Natural Disaster within 7 days of an event; d) Verified Physical Attack or a Verified Threat of Physical Attack from a third party;
e) the Insured had been deemed kidnapped or a Missing Person by local or international authorities and, when found, his or her safety and/or well-being are in question within 7 days of his or her being found.
Related Costs, as used in this Rider, means food, lodging and, if necessary, physical protection for the Insured during the Transport to the Nearest Place of Safety.
Security Evacuation, as used in this Rider, means the extrication of an Insured from the Host Country due to an Occurrence which results in the Insured being placed in Imminent Physical Danger.
Transport/Transportation, as used in this Rider, means the most efficient and available method of conveyance. In all cases, where practical, economy fare will be utilized. If possible, the Insured's Common Carrier tickets will be used.
Verified Physical Attack, as used in this Rider, means deliberate physical harm of the Insured confirmed by documentation or physical evidence.
Verified Threat of Physical Attack, as used in this Rider, means a threat against the Insured's health and safety as confirmed by documentation and/or physical evidence.

General Provisions

Entire Contract; Changes: This Policy, including any riders, endorsements or amendments, is the entire contract. Only Our authorized officer can authorize a change or waive any provisions in this Policy.

To be valid, any change or waiver must be in writing (or authorized electronic or telephonic communications). It must be signed by our President or Secretary and be attached to the Policy. The approval must be noted on or attached to this Policy. No agent has the authority to change or to waive any part of this Policy.

Agreement: We will provide the insurance described in this policy in return for the premium and compliance with all applicable provisions of this policy.

Non-Disclosure: For the first two years from the Effective Date of this Policy, any intentional material misrepresentation in relation to any matter affecting this Insurance shall render this Policy voidable at Our option. No misrepresentation shall be deemed material unless knowledge by Us of the facts misrepresented would have led Us to refuse to issue this policy.

Clerical Error: If a clerical error is made, it will not affect the insurance of the Insured. No error will continue the insurance of an Insured beyond the date it should end under this Policy.

Payment of Premium: Coverage is not effective unless the required premium has been paid, subject to the Grace Period.

Conformity With State Statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Not In Lieu Of Workers' Compensation: This Policy is not a Workers' Compensation policy. It does not provide Workers' Compensation benefits.

Claim Provisions

Notice of Claim: A claimant must give Us or Our authorized representative written (or authorized electronic or telephonic) notice of claim within 90 days after any loss covered by this Policy occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice should identify the Insured and the Policy Number.

Claim Forms: Upon receiving written notice of claim, We will send claim forms to the claimant within 15 days. If We do not furnish such claim forms, the claimant will satisfy the requirements of written proof of loss by sending the written (or authorized electronic or telephonic) proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

Proof of Loss: Written proof of loss must be furnished to Us at Our office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which We are liable and in case of claim for any other loss within 120 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required..

Time Payment of Claims: Any benefits due will be paid when We receive written (or authorized electronic or telephonic) proof of loss.

Payment of Claims: If the Insured dies, any death benefits or other benefits unpaid at the time of the Insured's death will be paid to the beneficiary. If no beneficiary is on record with Us or Our authorized agent, payment will be made to the first surviving class of the following to the Insured's: 1) spouse, domestic partner, partner to a civil union; 2) child or children, in equal shares (If a child is a minor, benefits will be paid to the legal guardian); 3) mother or father; 4) estate.

All other benefits due and not assigned will be paid to the Insured, if living.

Otherwise, the benefits may, at Our option, be paid: 1) according to the beneficiary designation; or 2) to the Insured's estate.

If We are to pay benefits to (1) a minor; or (2) a person who is incapable of giving a valid release, We may pay up to $1,000 to a relative by blood or marriage whom We believe is equitable entitled.

All other benefits due and not assigned will be paid to the Insured, if living. If the Insured is: (1) a minor; or (2) in Our opinion unable to give a valid release because of incompetence, We may pay any amount due to a parent, guardian, or other person actually supporting him or her, or to a person or persons chiefly dependent upon him or her for support or maintenance. Any payment made in good faith will end Our liability to the extent of the payment.

We may pay benefits directly to any Hospital or person rendering covered services, unless the Insured requests otherwise in writing. The Insured must make the request no later than the time he or she files a written proof of loss.

Beneficiary: The Insured may designate a beneficiary. The Insured has the right to change the beneficiary at any time by written (or electronic and telephonic) notice. If the Insured is a minor, his or her parent or guardian may exercise this right for him or her. The change will be effective when We or Our authorized agent receive it. When received, the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validity of a change.

Assignment: At the request of the Insured, medical benefits may be paid to the provider of service. Any payment made in good faith will end Our liability to the extent of the payment.

Physical Examinations and Autopsy: We have the right to have a Doctor of Our choice examine the Insured as often as is reasonably necessary when a claim is pending. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.

Legal Actions: No lawsuit or action in equity can be brought to recover on this Policy: (1) before 60 days following the date proof of loss was given to Us; or (2) after 3 years following the date proof of loss is required.

New York External Appeal Procedures

General Information

If You do not agree with the payment or denial of a claim, You and/or Your health care provider have the right to appeal the claim decision. When appealing a claim, You and/or Your health care provider should state all of the facts as to why the claim should be reconsidered and provide any additional supporting documentation. If We require any specific forms, such as a written authorization of representation or a medical records release consent form, such forms will be provided to the You within five (5) calendar days of receipt of the request for appeal.

You may contact ACE American Insurance Company at:

ACE American Insurance Company
CHUBB Customer Service Department
P.O. Box 1000
Philadelphia, Pennsylvania 19105-1000
1-800-352-4462

Your Right To An External Appeal

Under certain circumstances, You have a right to an external appeal of a denial of coverage. Specifically, if coverage is denied under the Policy on the basis that the service is not Medically Necessary or is an experimental or investigational treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent entity certified by New York State to conduct such appeals.

Your Right To Appeal A Determination That A Service Is Not Medically Necessary

If coverage is denied under the Policy on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You satisfy the following two criteria:

1. The service, procedure or treatment must otherwise be a Covered Expense under the Policy; and
2. You must have received a final adverse determination through Our internal appeal process and We must have upheld the denial or You and We must agree in writing to waive any internal appeal.

Your Right To Appeal A Determination That A Service Is Experimental or Investigational

If coverage is denied under the Policy on the basis that the service is an experimental or investigational treatment, You may appeal to an External Appeal Agent if You satisfy the following two criteria:

1. The service must otherwise be a Covered Expense under the Policy; and
2. You must have received a final adverse determination through Our internal appeal process and We must have upheld the denial or You and We must agree in writing to waive any internal appeal.

In addition, Your attending Doctor must certify that You have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of Your attending Doctor, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders You unable

to engage in any substantial gainful activities. In the case of a child under the age of 18, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

Your attending Doctor must also certify that Your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by the Policy or one for which there exists a clinical trial (as defined by law.)

In addition, Your attending Doctor must have recommended one of the following:

1. A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard covered service (only certain documents will be considered in support of this recommendation - Your attending Doctor should contact the New York State Department of Insurance in order to obtain current information as to what documents will be considered acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered).

For the purposes of this section, Your attending Doctor must be a licensed, board-certified or board eligible Doctor qualified to practice in the area appropriate to treat Your life-threatening or disabling condition or disease.

The External Appeal Process

If, through Our internal appeal process, You have received a final adverse determination upholding a denial of coverage on the basis that the service is not Medically Necessary or is an experimental or investigational treatment, You have 45 days from receipt of such notice to file a written request for an external appeal. If You and We have agreed in writing to waive any internal appeal, You have 45 days from receipt of such waiver to file a written request for an external appeal. We will provide an external appeal application with the final adverse determination issued through Our internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from the New York State Department of Insurance at (518) 474-4551. The completed application should be submitted to the New York Department of Insurance at the address indicated in the application. If You satisfy the criteria for an external appeal, the New York State Department of Insurance will forward the request to a certified External Appeal Agent.

You will have an opportunity to submit additional documentation with Your request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three business days to amend or confirm Our decision. Please note that in the case of an expedited appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision with 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Doctor or Us. If the External Appeal Agent requests additional information, it will have five additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two business days.

If Your attending Doctor certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three days of receipt of the completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment, We will provide coverage subject to the other terms and conditions of the Policy. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Policy will only cover the costs of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the Policy for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

Your Responsibilities

It is Your RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to You, Your Doctor may file an external appeal application on Your behalf, but only if You have consented to this in writing.

Under New York State law, Your completed request for appeal must be filed within 45 days of either the date upon which You receive written notification from Us that We have upheld a denial of coverage or the date upon which You receive a written waiver of any internal appeal. We have no authority to grant an extension of this deadline.

You may contact the New York State Insurance Department of Insurance at:

State of New York
Insurance Department
One Commerce Plaza
Albany, NY 12257

Phone: 518-474-6600
Toll-free: 1-800-342-3736

http://www.ins.state.ny.us

Cultural Insurance Services International – Claim Form

- **Program Name:** Colgate University
- **Policy Number:** 23 GLM N19005926-COLGATE
- **Participant ID Number** (from the front of your insurance card)**:**

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 yes, when was the last occurrence and/or doctor/hospital visit? _____

SECTION 4: REIMBURSEMENT***

Have these doctor/hospital bills been paid by you? ☐ YES ☐ NO
If no, do you authorize payment to the provider of service for medical services claimed? ☐ YES ☐ NO
If yes, you must include the payment receipt(s). Any eligible reimbursements will be made in U.S currency (USD) via check. If you would like your eligible reimbursement in another currency via wire transfer, please contact CISI at 203-399-5130 or claimhelp@mycisi.com for instructions.

Please note if you are submitting a claim for prescription medication, you must submit the prescription receipt. This will include your name, the name of the prescribing physician, name of the medication, dosage, date and amount billed. Cash register receipts will not be considered for reimbursement.

SECTION 5: FOR CLAIMS UNRELATED TO A MEDICAL INCIDENT PLEASE CHECK THE APPROPRIATE BOX BELOW:

In order to claim monies back related to one of the below benefits, you **MUST** submit the requested documentation found on the following page **(Page 2)**.

☐ **TRIP CANCELLATION AND INTERRUPTION** ☐ **LOST BAGGAGE** ☐ **BAGGAGE DELAY** ☐ **EMERGENCY REUNION**

Please provide us with the relevant details of your incident below or the details and value of your loss. You may attach an additional page if necessary:

_____

STOP! Please see next page for claim submission instructions specific to each of these benefits.

SECTION 6: CONSENT TO RELEASE MEDICAL INFORMATION

I hereby authorize any insurance company, Hospital or Physician or other person who has attended or examined me, including those in my home country to furnish to Cultural Insurance Services International or any of their duly appointed representatives, any and all information with respect to any sickness/illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical reports. A photo static copy of this authorization shall be considered as effective and valid as the original.

I certify that the information furnished by me in support of this claim is true and correct.

Name (please print): _____

Signature: _____Date:_____

Cultural Insurance Services International – Claim Form Page 2

Instructions for Claim Submission on Unrelated to a Medical Incident

Trip Cancellation, you must submit:

- Proof of non-refundable expenses must be provided.
- Proof of Payment.
- Letter stating reason for not traveling (if due to a medical condition, a detailed letter must be from the treating physician).
- If death of a family member, obituary or a copy of the death certificate is required as proof.

Trip Interruption, you must submit:

- Proof of non-refundable expenses must be provided.
- Proof of Payment
- Flight Itinerary including your name, travel dates and departure and arrival locations.
- Letter stating reason for curtailing travel (if due to a medical condition, the letter must be from the treating physician).
- If death of a family member, obituary or a copy of the death certificate is required as proof.

Baggage Delay, you must submit:

- Itemized listing of essential clothing and toiletries purchased.
- Proof of delay.

Lost Baggage, you must submit:

- Itemized listing of items lost or stolen with approximate values at the time of loss.
- Police Report or report and response from transportation carrier.

Emergency Reunion, you must submit:

- Proof of hospitalization, or if Felonious Assault, a report.
- Flight itinerary.
- Hotel Invoice.
- Meal Receipts.

Claimant Cooperation Provision: Failure of a claimant to cooperate with Us in the administration of a claim may result in the termination of a claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

For residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution or confinement in prison, or any combination thereof.

For residents of Arkansas, Louisiana, New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of District of Columbia: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kansas: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

For residents of Kentucky: Any person who knowingly and with intent to defraud any Insurance Company or other person files an application for insurance 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 crime.

For residents of Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Maine, Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an Insurance Company for the purpose of defrauding the Company. Penalties include imprisonment, fines and denial of insurance benefits.

For residents of Maryland: Any Person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit, or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New York: Any person who knowingly and with 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Oregon: Any person who knowingly, and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud.

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 claimants not residing in Alabama, Arkansas California, Colorado, District of Columbia, Florida, Kansas, Kentucky, Louisiana, Maine, Maryland, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Virginia nor Washington: Any person who, knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.