# Repatriation Claim Form

Repatriation covers preparation and return of your body to your Home Country for death due to a Covered Injury or Sickness. Covered Expenses include: Expenses for embalming or cremation; The least costly coffin or receptacle adequate for transporting the remains; Transporting the remains by the most direct and least costly conveyance and route possible and Pre-approved by the Assistance Company or Plan Administrator. This benefit excludes fees for return of personal effects, religious or secular memorial services, clergymen, flowers, music, announcements, guest expenses and similar personal burial preferences.

Submit this completed form along with:

- ◯ Approval from the Assistance Provider or Claims Administrator
- ◯ Billing Statement and Proof of Payment from Funeral Home listing costs for each service
- ◯ Paperwork from Embassy/Consulate
- ◯ Copy of the Death Certificate
- ◯ Proof of Travel to include Copy of Passport, Flight Booking and I-94

***Claimant Information:*** Insurance ID#_____

Last Name_____First Name_____

Date of Birth_____Date of Arrival:_____Coverage Effective Date: _____

Home Country Address: _____

Does the member have another insurance policy? : ◯ Yes Name of Company:_____ ◯ No

***Claim Information:***

Assistance Company/Claims Administrator Approval Number:_____Date Approved:_____

Cause of Death: _____

Date of Death:_____/_____/_____State and County of Death: _____

Was the Member Hospitalized: ◯ Yes From_____/_____/_____to_____/_____/_____ ◯ No

Name of Funeral Service Provider: _____

Cost of Local Burial:_____ Invoice #_____**Amount Claimed: _____**

Family Member providing information(Claimant): _____

Address:_____

Relationship to Member :_____Phone Number: _____

**Payment to - Check one** ◯ **Family Member (must provide receipt)** ◯ **Funeral Service Provider**

**Payment via - Check one** ◯ **Check** ◯ **EFT (**Us Banks ONLY**)**

For payment via EFT:

Bank Name:_____Bank Routing Number: _____

Account Number: _____

Name on Account: _____

**CLAIM FORM FRAUD STATEMENT - FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:** 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.

**ARIZONA**: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**ALASKA**: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**CALIFORNIA**: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fins and confinement in state prison.

**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.

**FLORIDA WARNING** :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.

**IDAHO**: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

**KANSAS**: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

**KENTUCKY**: Any person who knowingly and with intent to defraud any insurance company or other person files a 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

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

**NEW HAMPSHIRE**: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**NEW JERSEY**: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**NEW MEXICO and PENNSYLVANIA**: 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 subjects such person to criminal and civil penalties.

**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.

**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.

**TENNESSEE**: 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.

**TEXAS**: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**VIRGINIA**: Any person who, with the 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 may have violated state law.

**AUTHORIZATION:** In order to determine eligibility for claim benefits, claim payment amounts, and identification and prevention of potential fraudulent activity:

1. I authorize any physician; hospital or other medical or medically related facility or provider; insurance company; insurance support organization or fraud information clearinghouse to release to: the insurance company(ies) underwriting the policy, its representatives or business associates assisting in the processing of the claim, any information regarding the medical history, symptoms, treatment, examination results or diagnosis or such other information needed to determine claim benefits for the deceased named below; and
2. I authorize the insurance company(ies) underwriting the policy, its representatives or business associates assisting in the processing of the claim, to disclose the claims information submitted to the insurance company(ies), its representatives or business associates assisting in the processing of the claim, to any insurance support organization or fraud information clearinghouse utilized by the insurance company(ies), or its representatives or business associates. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for a period not to exceed one year from the date signed. I understand I have the right to receive a copy of this authorization and that I may revoke this authorization at any time for information not then obtained upon providing written notice of such revocation of the authorization to the insurance company(ies) underwriting the policy, its representatives or business associates assisting in the processing of the claim.

**Signature of claimant**: _____ Date: _____

**MAILING INSTRUCTIONS:**

Send this form and any accompanying documentation to:
Attention: Co-ordinated Benefit Plans, LLC On Behalf of Crum and Forster Insurance Company
PO Box 2069
Fairhope AL, 36533
OR
Email to: TrawickClaims@cbpinsure.com
Fax: 866-616-0444 or 251-666-1806
Customer Care: 866-696-0409 251-928-0939
Check claim status online at (Registration is required): https://mytrawick.com/Accounts/Member/Login

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