Point Comfort Underwriters, Inc.
306 Prospect Street, Indianapolis, IN 46225 USA
main +1.317.210.2010
fax 317.659.4610
toll free 844.210.2010
www.pointcomfort.com
my.pointcomfort.com
service@pointcomfort.com

CLAIMANT'S STATEMENT AND AUTHORIZATION

(See Part C for Directions for Submitting a Claim)

Clear Form

PART A: Complete for all claims		
Claimant (Patient) Name:		
☐ Male ☐ Female	Birthdate:	E-mail Address:
Main Telephone:		Home Country Address:
Work Telephone:		
Trip Registration Number (found on ID card): Passport Number:		Current Address:
Name of Primary Insured:		
Relationship to Primary Insured ☐ Self ☐ Spouse ☐ Child ☐ Other		
Citizenship of Claimant:		Home Country of Claimant:
Countries Visited:		
Is the Claimant a full-time student? ☐ Yes ☐ No		Name and address of school:
Is the Claimant Employed? ☐ Yes ☐ No		Name and address of employer:
Do you or any family members have other coverage (medical, indemnity or liability) which might help cover hospital and medical expenses? ☐ Yes ☐ No If yes, please provide the following:		
Name of Company:		Address:
Policyholder:		Policy Number:
Is this group insurance? ☐ Yes ☐ No		

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PART B: Complete for new claims. (If you need additional space, please attach additional sheets.)

1. How did the condition begin? State fully all symptoms and describe the condition in detail from the beginning:

2. When did the first symptoms of this condition begin? State the exact date, if possible. (If due to an accident, please complete the accident questionnaire, see Part C – DIRECTIONS)

3. Have you ever had or been treated for the same kind of illness or injury? ☐Yes ☐No
   If Yes, when? (Name, address and telephone number of physician)

4. Name, address and telephone number of family physician (even if not consulted):

5. What ailments, diseases, illnesses, conditions or injuries have you had during the last five years? Please provide name and/or description of each condition, dates involved, and the name, address and telephone numbers for physicians:

6. Is this the result of an accident or illness:
   a. Related to Employment? ☐ Yes ☐ No
      If yes, are you applying for Worker's Compensation benefits? ☐ Yes ☐ No
   b. Involving a motor vehicle? ☐ Yes ☐ No
      If yes, please list the names of involved parties, insurance carries and policy numbers.
   c. Was a police report filed? ☐ Yes ☐ No
      If yes, please identify the Police Department where it was filed.

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PART C: Complete for all claims

I verify that all information contained in this form is true, correct and complete to the best of my knowledge. I authorize any licensed doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial or employment status of the insured named below, to provide this information to Point Comfort Underwriters. I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be valid as the original. This authorization is valid for twelve months from the date signed:

Signature of Primary Insured:	
Print Name:	Date:

Signature of Claimant (Patient):	
Print Name:	Date:

ASSIGNMENT OF BENEFITS AUTHORIZATION: I authorize payment of medical benefits to the doctor or other supplier of services submitting the attached bills.

Signature of Primary Insured:	Date:

DIRECTIONS FOR SUBMITTING A CLAIM

1. If this is a new claim, complete ALL PARTS of this form.
2. If this claim is a result of an accident, please visit my.pointcomfort.com, " Forms" to obtain the ACCIDENT QUESTIONNAIRE, or contact our office to request the form.
3. If this is a continuing claim, complete Parts A and C only.
4. Attach all original itemized bills for services and supplies. Please verify that the documents indicate your name, date of service, diagnosis and the charge for each service.
5. Mail to: **POINT COMFORT UNDERWRITERS** Fax: **317.659.4610**
   306 Prospect Street, Suite 100 E-mail: **service@pointcomfort.com**
   Indianapolis, IN 46225 USA
6. If you have any questions, call 1-844-210-2010. If calling from outside the US, call collect to (317) 210-2010.

INDIANA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

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Continuation of Claimant's Statement & Authorization Form information: