PROOF OF LOSS

Chartis Claims, Inc. **Accident and Health Claims Department** **Gencon Claims Department** **12501 Old Columbia Pike** **Silver Spring, MD 20904** **(800) 551-0824 (Telephone)**	**UNDERWRITTEN BY:** **GROUP NAME:** **POLICY #:**	**The Ins. Company of the State of Pennsylvania** **Gencon** **GLB 9017494**

FORMULÁRIO DE SINISTRO PARA ACIDENTE E DOENÇAS - CAMPERS

ACCIDENT AND SICKNESS CLAIM FORM / GLOBAL

INSTRUCTIONS:

1. Este formulário é para ser usado quando acionar um sinistro para reembolso de gastos médicos.
1. THIS FORM IS TO BE USED WHEN FILING A CLAIM FOR REIMBURSEMENT OF MEDICAL EXPENSES
2. SECTION A MUST BE COMPLETED BY THE INSURED IN FULL. 2. Seção A deve ser completa pelo segurado completamente.
3. ONE OF THE FOLLOWING MUST BE PROVIDED: 3. Um dos seguintes itens deve ser fornecido:
   - FULLY COMPLETED MEDICAL FORM BY THE ATTENDING PHYSICIAN, AND/OR Formulário médico completo pelo médico ou
   - FULLY ITEMIZED BILLS FROM TREATMENT CENTERS SHOWING CLAIMANT'S NAME, NATURE OF ILLNESS/INJURY, DESCRIPTION AND CHARGE FOR EACH SERVICE. todas as notas de tratamento com o nome do sinistrado - detalhes gastos.
4. THIS FORM MUST BE SIGNED AND DATED IN ALL APPLICABLE SECTIONS. 4. Este formulário deve ser assinado e datado.
5. THIS FORM AND ALL ATTACHED BILLS MUST BE SUBMITTED TO THE ADDRESS INDICATED ABOVE. 5. Enviar notas e formulário
6. READ, COMPLETE, AND SIGN THE AUTHORIZATION AND ASSIGNMENT OF BENEFITS SECTION ON THE FOLLOWING PAGE. para ARM SA.
6. Leia, complete e assine a autorização e destino de beneficios na próxima página.

THE FURNISHING OF THIS FORM, OR ITS ACCEPTANCE BY THE COMPANY, MUST NOT BE CONSTRUED AS AN ADMISSION OF ANY LIABILITY ON THE COMPANY, NOR A WAIVER OF ANY OF THE CONDITIONS OF THE INSURANCE CONTRACT.

SECTION A: MEMBER / CLAIMANT INFORMATION MEMBRO / INFORMAÇÕES DO SINISTRADO

INSURED / MEMBER NAME Segurado - nome membro	ADDRESS OF INSURED / MEMBER Endereço do segurado - membro		
CLAIMANT (PATIENT) NAME Nome do sinistrado (paciente)	ADDRESS OF CLAIMANT (IF DIFFERENT THAN MEMBER'S) Endereço do Sinistrado (se diferente do anterior)		
DATE OF ARRIVAL IN UNITED STATES: (MO / DAY / YEAR) Data chegada evento Relação do segurado com o membro	PERMANENT ADDRESS (IN HOME COUNTRY): Endereço permanente (se diferente do anterior)		
CLAIMANT'S RELATIONSHIP TO MEMBER ☐ SELF EU ☐ SPOUSE Esposo ☐ CHILD Filho	CLAIMANT'S GENDER ☐ MALE ☐ FEMALE Sexo	CLAIMANT'S DATE OF BIRTH: Data de nascimento	CLAIMANT SOCIAL SECURITY #: N° Documento
IF CLAIMANT IS A MINOR, NAME OF GUARDIAN: Se o sinistrado é menor, nome do responsável	ARE YOU FLUENT IN ENGLISH? ☐ YES ☐ NO Fala Inglês? IF NO, GIVE PRIMARY LANGUAGE: Se não, qual idioma fala?		
PRIMARY DAYTIME PHONE #: Fone residencial	SECONDARY DAYTIME PHONE #: Fone celular	EMAIL ADDRESS: Endereço e-mail	FAX NUMBER: número de fax

SECTION B: INSURANCE / PHYSICIAN INFORMATION SEGURO / INFORMAÇÕES DO MÉDICO

HAVE OTHER HEALTH INSURANCE? ☐ YES ☐ NO Outro seguro?	IF YES, PLEASE PROVIDE THE FOLLOWING: Se sim, responda o seguinte: COMPANY NAME: Nome Seguradora	GROUP NAME: Nome Grupo	POLICY NUMBER: N° apólice
NAME OF CURRENT TREATING PHYSICIAN: Nome do médico que atendeu:	ADDRESS OF TREATING PHYSICIAN: Endereço do médico que atendeu:	TREATING PHYSICIAN PHONE #: Fone do médico que atendeu:	
NAME OF REGULAR PHYSICIAN (IN HOME COUNTRY): Nome do médico regular:	ADDRESS OF REGULAR PHYSICIAN (IN HOME COUNTRY): Endereço do médico regular:		

SECTION C: ACCIDENT / SICKNESS DETAILS ACIDENTE / DETALHES DA DOENÇA

IF ACCIDENT, PLEASE COMPLETE THE FOLLOWING: Se acidente, por favor, complete a seguir:	WHEN DID THE ACCIDENT HAPPEN: (MO / DAY / YEAR) Quando aconteceu	SPECIFY TIME: Horário ☐ AM ☐ PM
WHERE DID ACCIDENT HAPPEN (PLEASE BE SPECIFIC): Onde o acidente aconteceu (por favor, seja específico)	HOW DID ACCIDENT HAPPEN (PLEASE GIVE DETAILS AND SPECIFY BODY PART) Como o acidente aconteceu (por favor, dê detalhes e especifique a parte do corpo)	
IF SICKNESS, PLEASE COMPLETE THE FOLLOWING: Se doença, por favor, complete a seguir:	WHEN DID THE SYMPTOMS BEGIN: (MO / DAY / YEAR) Quando os sintomas começaram	DATE FIRST TREATED: (MO / DAY / YR) Data do 1° tratamento
WHERE DID SYMPTOMS FIRST OCCUR: Onde os sintomas primeiramente ocorreram:	PLEASE DESCRIBE SYMPTOMS Por favor, descreva os sintomas	

WERE YOU TAKING MEDICATIONS PRIOR TO YOUR ACCIDENT OR SICKNESS? ☐ YES ☐ NO Tomava medicamentos antes desse caso?
IF YES, PLEASE COMPLETE THE BELOW: Se sim, por favor, complete abaixo:

DRUG NAME: .	PRESCRIBED FOR: .	PHYSICIAN NAME: .	DATE FIRST PRESCRIBED: .
Nome da droga	Prescrito por:	Nome do médico	1ª data da receita

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, THE UNDERSIGNED AUTHORIZE ANY HOSPITAL OR OTHER MEDICAL-CARE INSTITUTION, PHYSICIAN OR OTHER MEDICAL PROFESSIONAL, PHARMACY, INSURANCE SUPPORT ORGANIZATION, GOVERNMENTAL AGENCY, GROUP POLICYHOLDER, INSURANCE COMPANY, ASSOCIATION, EMPLOYER OR BENEFIT PLAN ADMINISTRATOR TO FURNISH TO THE INSURANCE COMPANY NAMED ABOVE OR ITS REPRESENTATIVES, ANY AND ALL INFORMATION WITH RESPECT TO ANY INJURY OR SICKNESS SUFFERED BY, THE MEDICAL HISTORY OF, OR ANY CONSULTATION, PRESCRIPTION OR TREATMENT PROVIDED TO, THE PERSON WHOSE DEATH, INJURY, SICKNESS OR LOSS IS THE BASIS OF CLAIM AND COPIES OF ALL OF THAT PERSON'S HOSPITAL OR MEDICAL RECORDS, INCLUDING INFORMATION RELATING TO MENTAL ILLNESS AND USE OF DRUGS AND ALCOHOL, TO DETERMINE ELIGIBILITY FOR BENEFIT PAYMENTS UNDER THE POLICY NUMBER IDENTIFIED ABOVE. I AUTHORIZE THE GROUP POLICYHOLDER, EMPLOYER OR BENEFIT PLAN ADMINISTRATOR TO PROVIDE THE INUSRANCE COMPANY NAMED ABOVE WITH FINANCIAL AND EMPLOYMENT-RELATED INFORMATION, I UNDERSTAND THAT THIS AUTHORIZATION IS VALID FOR THE TERM OF COVERAGE OF THE POLICY IDENTIFIED ABOVE AND THAT A COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL. I UNDERSTAND THAT I OR MY AUTHORIZED REPRESETATIVE MAY REQUEST A COPY OF THIS AUTHORIZATION.

EU AUTORIZO PAGAMENTO DE BENEFÍCIOS MÉDICOS PARA O MÉDICO OU FORNECEDOR DE SERVIÇOS PRESTADOS.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICE PROVIDED.	☐ YES SIM	☐ NO NÃO

ATRIBUIÇÃO LIMITADA OPCIONAL

OPTIONAL LIMITED ASSIGNMENT

I HEREBY MAKE A LIMITED ASSIGNMENT TO _____ (MY "ASSIGNEE") OF THE RIGHT TO RECEIVE THE BENEFITS DUE FOR THOSE COVERED MEDICAL EXPENSES INCURRED BY ME AND ACTUALLY PAID DIRECTLY TO THE PROVIDER OF THOSE SERVICES BY MY ASSIGNEE. I UNDERSTAND THAT THE COMPANY BEARS NO RESPONSIBILITY OR LIABILITY FOR THE VALIDITY OR EFFECT OF THIS ASSIGNMENT OR FOR ANY PAYMENTS MADE BY THE COMPANY PRIOR TO RECEIPT OF SATISFACTORY PROOF OF PAYMENT BY THE ASSIGNEE. I HEREBY SPECIFICALLY RELEASE, AND AGREE TO INDEMNIFY, THE COMPANY FROM ANY AND ALL LIABILITY INCURRED FOR ANY SUCH PAYMENTS MADE.

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 FINES AND CONFINEMENT IN STATE PRISON.

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 NEW YORK: 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, AND ANY PERSON WHO KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR COVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLE OR AN INSURANCE COMPANY 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 VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

FOR RESIDENTS OF PENNSYLVANIA: 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 CONCELAS 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 CALIFORNIA, RHODE ISLAND, NEW YORK, OR PENNSYLVANIA: 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.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

EU CERTIFICO QUE A INFORMAÇÃO ACIMA É VERDADEIRA E CORRETA PARA O MELHOR DO MEU CONHECIMENTO

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE: ASSINATURA DO SINISTRADO OU PESSOA AUTORIZADA	DATE: DATA