CLAIM FORM

This Claim Form should only be used if the provider did not send a request directly to VUMI® Insurance Europe Limited and its subsidiaries or affiliates on its behalf. Send this form together with the invoices or receipts with the amounts broken down, diagnoses, and medical prescriptions to the address below.

CLAIM FORM REQUIREMENTS:

- Complete this form and submit with all corresponding information within 180 days from the initial date of service.
- If information is not received within the established period, the claim will not be covered.
- Present one claim form per event, per family member.
- Attach invoices detailing all services received plus proof of payment for expenses incurred.
- All services rendered inside the United States must be accompanied by the Release of Information Form to obtain medical information from the provider if necessary.

SEND THIS CLAIM FORM WITH INVOICES AND/OR RECEIPTS TO: contact-europe@vumigroup.com.

Section I. Claimant Information

1. Claimant's full name:
2. Date of birth:
3. Policyholder's full name:
4. Policy number:
5. Email address:

Section II. Medical Information

1. Diagnosis:
2. Main symptoms:
3. Date of onset of symptoms:
4. Projected treatment or procedure and prognosis:
5. Has there been a prior diagnosis and/or treatment for the same or another related condition?: ○ Yes ○ No
6. Date of first consultation:
7. If the answer is yes, provide dates, results, type of treatment, prescribed medications, and name of the doctor or hospital:

DOES THE PATIENT ALSO HAVE COVER FROM:

8. Another health insurance plan?: ○ Yes ○ No
9. If the answer is yes, provide the name and address of the other insurer:

WAS THE ILLNESS OR INJURY, IN ANY WAY, A RESULT OF:

10. The patient's profession: ○ Yes ○ No
11. An accident of any type?: ○ Yes ○ No
12. If the answer is yes, provide details, including the date of the accident: (in case of an automobile accident, include a police report)

DOCTOR / HOSPITAL INFORMATION:

1. Doctor's name / department / provider:

2. Phone number:
+ -

3. Address:

4. Alternative Phone number:
+ -

5. Doctor's signature:

6. E-mail address:

7. Treating physician's stamp:

If the doctor information section is completed, signed and stamped by the treating physicians this form will be valid as a medical report.

Section III. Detailed invoice information

MEDICAL SERVICES

DATE OF SERVICE FROM:	TO:	DESCRIPTION OF PROCEDURES, MEDICAL SERVICES AND SUPPLIES FURNISHED	CURRENCY	CHARGES
		TOTAL CHARGES:		
		AMOUNT PAID BY THE INSURED:		

PRESCRIBED MEDICATION

DATE OF SERVICE FROM:	TO:	DESCRIPTION OF PROCEDURES, MEDICAL SERVICES AND SUPPLIES FURNISHED	CURRENCY	CHARGES
		TOTAL CHARGES:		
		AMOUNT PAID BY THE INSURED:		

Section IV. Reinbursement information

PAYMENT METHOD

1. Last name(s):

2. First name(s):

3. Address:

4. City:

5. State:

6. Country:

7. Postal Code:

8. Phone number: (must be associated with the country where the check is being sent)

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The minimum amount to send an international check is US$500 per policy, all claims combined.

○ **Option 1**: International Wire Transfer

1. Account type:

○ Checking ○ Savings

2. Bank name:

3. Primary accountholder name:

4. Account number / IBAN:

5. SWIFT / BIC code:

6. Intermediary bank name (if applicable):

7. Intermediary bank wire routing number (must be 9 digits):

8. Referential details:

○ **Option 2:** Apply to premium

I authorise VUMI® Insurance Europe Limited (the Company) to apply the amount to be reimbursed from this claim solely towards payment of the next renewal premium for this policy number. I understand this authorisation does not guarantee that my policy will be renewed on time. I'm responsible for making sure any outstanding premium at the time of renewal is paid in full should the reimbursement(s) not be enough to cover the full premium before the grace period ends. I understand that the renewal amount might change if rates go up or if my cover changes. It doesn't change the rules of my policy, especially those about paying premiums and rate changes. VUMI® Insurance Europe Limited may accept or decline this request and may set limits on how reimbursements can be used in the future.

I agree and give my consent for VUMI® Insurance Europe Limited and its subsidiaries and affiliates to send and obtain information regarding my health to/from an authorised medical team, hospitals, health clinics, public health authorities, insurers and similar institutions, in order to prove the veracity of this claim. This consent applies only for the illnesses, injuries and diagnoses indicated. I declare that the information provided by me is true, complete and given in good faith. If any of the information disclosed here is false, incorrect, incomplete, had the intention of misleading or deceiving or was omitted, I understand the policy will be canceled and the Company will not be responsible for any payments of the benefits offered under the plan. I agree to reimburse any payment made as a result of an omission, incorrect disclosure or negligence caused by me.

1. Full name of the insured:

2. Signature of the insured:

3. Date: