Rutgers University International Travel Medical Insurance
CLAIM FORM

Plan Design: The International Travel Insurance Plan provides benefits for the reasonable and customary charges incurred by a participant for a covered Accident or Sickness up to $500,000 per person per occurrence. Coverage will be provided for each benefit or service as listed in the summary below. Pre-existing conditions are covered and there is no deductible.

COVERED SERVICES	BENEFITS
Medical Expenses - office visits, hospitalizations, and prescriptions	$500,000
Dental Expenses because of an accident	$2,000
Trip Interruption	$4,000
Accidental Death & Dismemberment	$10,000

Participants are advised to contact International SOS if faced with a medical emergency or need provider referrals when abroad. ***Please note:*** *the insurance does not cover routine physicals, routine dental visits, immunizations, or preventative/wellness services.*

If a participant pays out of pocket for medical expenses then the participant must submit a claim for reimbursement by completing the below information. If International SOS guarantees payment for medical expenses on the participant's behalf a claim does not need to be submitted because International SOS will direct bill the claims administrator.

Please complete the section below and follow the submission instructions at the bottom of this page.

Program Sponsor: Rutgers University International Travel Medical Insurance Program

Policy Number: NWT2017086-4

Participant Name: _____ Date of Birth: _____ Gender: Male ☐ Female ☐

Student ID or Employee ID (if available): _____

Diagnosis or reason for medical or prescription expense: _____

Please indicate who the reimbursement check should be sent to:
Note: *Checks can be made payable to the participant or Rutgers University. If the Rutgers University is submitting for reimbursement, please attach a W-9.*

Participant Name or Rutgers University: _____

Street: _____

City: _____ State: _____ Zip: _____

To submit your claim, please send/scan this form with the itemized bill(s) and proof of payment to the below address or email address:

Consolidated Health Plans
2077 Roosevelt Ave
Springfield, MA 01104

(800)-633-7867
customerservice@consolidatedhealthplan.com