Primary Medical Expense Claim Form

Claims Department:
Red Sky Claims, C/O Arch Insurance Company
Executive Plaza IV, 11350 McCormick Road, Suite 102, Hunt Valley, MD 21031 S l grcb Qr_rcq
Toll Free Phone: (822) 8 . .+0264 | **Fax:** (443) 279-2901 | **E-mail:** redsky@archinsurance.com
Any person who knowingly presents a false or fraudulent claim for payment of 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.

Arch Insurance Company®
Powering Specialty Risk Solutions®

To be Completed by Insured / Guest

Name of Insured / Guest			Reservation #
Address		Work Phone # ( )	Home Phone # ( )
		Date of Birth (mm/dd/yy)	E-mail Address
Date of Initial Trip Deposit (mm/dd/yy)	Scheduled Departure Date (mm/dd/yy)	Scheduled Return Date (mm/dd/yy)	Date Incident Occurred (mm/dd/yy)
Name and Address of Property Management Company			Phone # ( )
			Fax # ( )
Name of leaseholder on the rental property and list all guests occupying the property			
Name of Patient		Relationship to Insured / Guest	
Are you a U.S. Citizen? ☐ Yes ☐ No		Date symptoms first appeared (mm/dd/yy)	
Give Nature of Sickness or Injury (Diagnosis)		Date of initial treatment for this condition (mm/dd/yy)	
Describe fully how, when and where Sickness / Injury Occurred			
Was there previous treatment for these conditions prior to purchase of plan? ☐ Yes ☐ No If yes, when?			
Name and address of primary care physician where you reside		Physician's Phone # ( )	Physician's Fax # ( )
Name and address of other physician(s) who treated the condition		Physician's Phone # ( )	Physician's Fax # ( )
Name and address of Hospital (if hospitalized)		Date Admitted and Discharged	Hospital Phone # ( )
Was an accident report filed for this incident? ☐ Yes ☐ No		If yes, please provide a copy.	

Note: Your Travel Insurance Policy is Primary to any other health, medical, and travel insurance you may have.

Do you have any other medical Insurance? ☐ Yes ☐ No	
Please list all of your other medical insurance plans (group health, Medicare, supplemental, etc.)	

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Please include the following items with your claim forms after completing page 1 of this form. Any omitted items will delay processing. You may want to send any valuable documents by certified mail.

- ✓ Your cancelled check or credit card statement for the initial trip deposit.
- ✓ Copies of explanation of benefits from the primary carrier and all medical bills incurred while on your trip from your other insurance in the form of standard UB and HCFA billing statements.
- ✓ Completed and signed claim form
- ✓ Copy of rental agreement
- ✓ Credit card statement, cancelled checks, or cash receipt for all medical payments while on your trip
- ✓ If Claimant is other than leaseholder, please provide a signed written statement from leaseholder listing all guests occupying the rental property.

Claimed Expenses

_____ Total amount paid for all medical treatment received while on trip (Attach all invoices)

_____ Total amount reimbursable from other sources (Attach all responses received)

_____ Total amount being claimed from Red Sky

Authorization to Disclose Information

Trip Preserver Product is Underwritten by **Arch Insurance Company.**

To any medical care provider, medical care facility, Insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Arch Insurance Company, or its authorized representative. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The Company will use this information to determine if my claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigative or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effect and valid as the original and shall remain in effect for one year from the date of authorization. I certify that the information given by me in support of my claim is true and correct.

Patient's or Authorized Representative's Signature _____ Date _____

If Authorized Representative, Relationship to Patient _____

or Legal Designation _____

Assignment of Benefits

I Authorize the Claims Administrator, to pay benefits in connection with this claim directly to the doctor, hospital, or other provider.

Patient's or Authorized Representative's Signature _____ Date _____

If Authorized Representative, Relationship to Patient _____

or Legal Designation _____