

Pet Medical Claim Form



Please print legibly and complete ALL SECTIONS before submitting.

Email: iTravelClaims@imglobal.com

Additional submission options below.

To report a loss, return the required documentation, along with your original, signed claim form to IMG.

A delay in the processing of the claim will occur if unacceptable proof of loss or an incomplete claim form is submitted. Proof of claim must be submitted within 90 days of the date of loss. IMG reserves the right to obtain further information needed to determine eligibility for benefits and the proper payee.

1. POLICYHOLDER INFORMATION

Full Name (Last, First, Middle):	Policy Number:
Address:	
Phone Number:	
Email:	
Trip Dates: From: ____/____/____ (MM/DD/YYYY) To: ____/____/____ (MM/DD/YYYY)	

Please note: by providing an email address and cell phone number on this form, you agree to electronic communications (including emails and SMS) about any claims that you have submitted.

2. PET INFORMATION

Pet Name:	
Species/Breed:	
Age:	
Primary Veterinarian:	Vet Phone Number (With area code):

3. PET MEDICAL EXPENSES DURING TRIP

Provide a brief explanation of the pet medical expenses:

4. PET MEDICAL CLAIM DETAILS

Incident Information	Treatment Provider	Expenses	Required Attachments
Date of Illness/Injury: ____/____/____ (MM/DD/YYYY)	Veterinary Clinic Name: _____	Total Veterinary Charges: \$ _____	Itemized veterinary bill ☐
Date of Treatment if different from above: ____/____/____ (MM/DD/YYYY)	Address: _____	Medications Prescribed: _____	Medical records or exam notes ☐
Description of Condition:	Phone: _____	Follow-up Care Needed: ☐ Yes ☐ No	Proof of payment ☐

5. REFUNDS OR REIMBURSEMENTS RECEIVED

Have you received any refund or reimbursements from another source?

☐ Yes ☐ No

If Yes, provide details:

6. PAYMENT INFORMATION

Payee/Beneficiary

Bank Name:

Account Number:

ACH Routing Number:

REQUESTOR AUTHORIZATION

By signing below, I request for an accommodation from and for Company to execute the above funds transfer instruction up to the amount of benefits owed in accordance with under the insurance contract for funds transfers set forth in this agreement. I understand and acknowledge Recipients may

receive less due to fees charged by the Recipient's bank and taxes, and any cancellation must occur within 30 minutes of sending the request, unless the funds have already been picked up or deposited.

Authorized Signature: **X** _____

Date: ____/____/____ (MM/DD/YYYY)



If using this form, please print legibly and complete ALL SECTIONS before submitting.

Email: iTravelClaims@imglobal.com

Web: www.imglobal.com/secure-message-center

Address: IMG iTravelinsured® Claims, P.O. Box 241853, Apple Valley, MN 55124 USA,

Call: 1.317.655.9798

www.imglobal.com

**CLAIM FORM FRAUD STATEMENT
FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:**

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.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ALASKA and KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

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.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully

presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals 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.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TENNESSEE and VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, 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 stated value of the claim for each such violation.

AUTHORIZATION

The undersigned authorizes any health plan, healthcare provider, healthcare professional, MIB, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency, employer, benefit plan, or any other organization or person that has provided care, advice, diagnosis, payment, treatment, or services to the insured or on the insured's behalf, has any records or knowledge of the insured's health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the insured, and any non-medical information about the insured, to disclose the insured's entire medical record, file, history, medications, and any other information concerning the insured and to give any and all such information to the insured's agent of record and authorized representatives of the insurer, IMG, and their affiliates, and subsidiaries.

This information will be used to evaluate claims for benefits. Individuals have the right to refuse to sign the authorization without negative consequences to treatment or plan enrollment, except IMG will not be able to administer claims, determine benefit eligibility, or issue payments. The authorization is valid for the term of the insurance contract or plan under which a claim has been submitted. The undersigned understands that the insured has the right to receive a copy

of this authorization upon request and revoke the authorization at any time in a written communication to IMG. A copy of this shall be as valid as the original. The undersigned acknowledges and understands there is the potential for the information to be subject to redisclosure by the recipient and to no longer be protected by applicable privacy and confidentiality laws.

The undersigned represents and warrants information or documents provided to IMG by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees:

- 1) Any insurance coverage or benefit is contingent upon any statement made to IMG as being complete and correct
- 2) Benefits under any contract will be paid only if IMG decides the applicant is entitled to them

Signature of Insured/Claimant: **X** _____

Date: ____/____/____ (MM/DD/YYYY)