Redbridge®
Insurance Company, Ltd.

# Claim Form

**TO BE COMPLETED BY CARDHOLDER**

## I-GENERAL NFORMATION

| Certificate Number | Passport Number | Effective Date (MM/DD/YYYY) | Termination Date (MM/DD/YYYY) |
|---|---|---|---|
| | | / / | / / |

| | | | |
|---|---|---|---|
| Client (Cardholder) Full Name: | Name(s) Last Name | Gender [ ] Female [ ] Male | Date of Birth (MM/DD/YYYY) / / |
| Eligible Dependent Full Name: | Name(s) Last Name | Gender [ ] Female [ ] Male | Date of Birth (MM/DD/YYYY) / / |
| Address of person submitting the claim: | Street City State Country Zip Code | | |

| Email Address: | | Residential Telephone: | | Cellular Number: | |
|---|---|---|---|---|---|

## II-CLAIM DETAILS

| Type of Claim: [ ] Accident [ ] Disease [ ] Injury [ ] Luggage [ ] Other<br>Other (Explain): _____ | Date of Occurrence (MM/DD/YYYY) / /<br>Place of Occurrence |
|---|---|
| Offer details: | Amount Claimed |

IN THE EVENT OF A MEDICAL ASSISTANCE CLAIM:

| | |
|---|---|
| Have you had similar or the same symptoms previously? | [ ] Yes [ ] No |
| Have you previously received treatment for this condition? | [ ] Yes [ ] No |
| If affirmative, where and since when? | |
| Attending physician name: | |
| Attending physician address: | |
| Attending physician contact information: | |

## III- AUTHORIZATION TO RELEASE MEDICAL INFORMATION

As evidence with my signature below, I authorize any licensed physician, medical practitioner, hospital, clinic or any medical establishment or medically related, insurance company, governmental agency, MIB, Inc. ("MIB) or any organization, institution or person having records or knowledge about me or my health and my dependents named on the application to disclose to Redbridge, affiliates and reinsurers such information, including copies of records related to any advice, care or treatment provided to me or my dependents, without any limitation to information related with mental illnesses, use of drugs and/or alcohol.

A photocopy of this authorization shall be as valid as the original.

| Client's Signature (Cardholder) | Eligible Dependent Signature (18 years or older) | Date (MM/DD/YYYY) / / |
|---|---|---|