World Learning International Travel Insurance
CLAIM FORM - Outbound

Plan Design: Coverage will be provided for each benefit or service as listed in the summary below. For a full list of benefits please refer to the Evidence of Benefits. Pre-existing conditions are covered and there is no-deductible.

COVERED SERVICES	BENEFITS (per person per occurrence)
Medical Expenses - office visits, hospitalizations, and prescriptions	$500,000
Trip Interruption	$2,000
Dental for Accidental Injury to Natural Teeth	$750
Baggage/ Personal Effects	$500 per item to a max of $5,000
Travel Assistance Services listed below need to be provided by International SOS	
Medical Evacuation or Medically Necessary Repatriation	$500,000
Repatriation of Mortal Remains	$100,000
Visit by Family Member or Friend	$20,000, to include meals & accommodations $500/day
Return of Dependent Children	$5,000
Political and Natural Disaster Evacuations	$100,000

Participants are advised to contact International SOS if faced with a medical emergency or 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: World Learning International Travel

Policy Number: NWT2016095

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

School Student ID or Employee ID (if available): _____

Diagnosis or reason for medical or prescription expense: _____

Person Completing Form: _____

Phone # for Person Completing Form: _____

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

Program Sponsor or Participant Name: _____

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