# 2014-2015 Medical University of South Carolina
# International Travel Insurance Claim Form

**Plan Design:** The 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** - including office visits, hospitalizations, prescriptions, and maternity | $500,000 |
| Dental (Emergency) | up to $750 |
| Trip interruption – Return ticket | $2,000 |
| **CALL INTERNATIONAL SOS AT 215-942-8478 TO RECEIVE THE BELOW BENEFITS NO CLAIM FORM NEEDED** | |
| 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 |
| Visit by Family Member or Friend due to Felonious Assault | $5,000, to include meals & accommodations $500/day |
| Political and Natural Disaster Evacuations | $100,000/Evacuation |

Members are advised to contact International SOS if faced with a medical or security emergency abroad. Members are also advised to contact International SOS for medical referrals. *Please note that the insurance does not cover routine physicals, routine dental visits, immunizations, or preventative/wellness services.*

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

**Claim Slip:**
Please complete the below and send it to Consolidated Health Plans with a copy of the itemized bill (translated into English, if possible).

Program Name: Medical University of South Carolina International Travel Insurance Program
Policy Number: NWT2014059

Student Name: _____

Student ID: _____

Mailing Address: _____
(The address the reimbursement check will be sent to)

Diagnosis or reason for medical or prescription expense: _____

**Please send/scan this form to the below address or email address with the itemized bill(s):**
**Consolidated Health Plans**
**2077 Roosevelt Ave**
**Springfield, MA 01104**
**(800)-633-7867**
**customerservice@consolidatedhealthplan.com**