Safe Travels Local Burial Claim Form

LOCAL BURIAL BENEFIT is for preparation, local burial or cremation of the mortal remains at the time of death. Must be approved in advance by the Assistance Company. Includes death due to a Pre-existing Condition. The Company will pay the reasonable Covered Expenses incurred for preparation, local burial or cremation of mortal remains at the country of death in accordance with the commonly accepted cultural and religious beliefs practiced.
Coverage is not provided for cost incurred for religious practitioner, flowers, music, food or beverages. Failure to utilize the Assistance Company to approve these services will result in the complete denial of benefits.

Submit this completed form along with:

◯ Approval from the Assistance Provider
◯ Billing Statement from Funeral Home listing costs for each service
◯ Paperwork from Embassy/Consulate
◯ Copy of the Death Certificate
◯ Proof of Travel to include Copy of Passport, Flight Booking and I-94

Member Information: Member Ins ID#_____

Last Name _____First Name_____

Date of Birth _____ Date of Arrival: _____ Coverage Effective Date: _____

Home Country Address: _____

Does the member have another insurance policy? : ◯ Yes Name of Company: _____ ◯ No

Claim Information:

Assistance Company Approval Number: _____ Date Approved:_____

Cause of Death: _____

Date of Death: _____/_____/_____ State and County of Death: _____

Was the Member Hospitalized: ◯ Yes From_____/_____/_____ to _____/_____/_____ ◯ No

Name of Funeral Service Provider: _____

Cost of Local Burial: _____ Invoice # _____ **Amount Claimed: _____**

Family Member providing information(Claimant): _____

Address: _____

Relationship to Member : _____ Phone Number: _____

Payment to - Check one ◯ **Family Member (must provide receipt)** ◯ **Funeral Service Provider**

Payment via - Check one ◯ **Check** ◯ **EFT (**Us Banks ONLY**)**

For payment via EFT:

Bank Name: _____Bank Routing Number: _____

Account Number: _____

Name on Account: _____

Authorization & Legal Notifications

(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.

(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.

(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

(**Louisiana**) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

(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.

(Puerto Rico) Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

(Washington) Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."

(All Other States) 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/or civil penalties.

AUTHORIZATION: In order to determine eligibility for claim benefits, claim payment amounts, and identification and prevention of potential fraudulent activity:

1. I authorize any physician; hospital or other medical or medically related facility or provider; insurance company; insurance support organization or fraud information clearinghouse to release to: the insurance company(ies) underwriting the policy, its representatives or business associates assisting in the processing of the claim, any information regarding the medical history, symptoms, treatment, examination results or diagnosis or such other information needed to determine claim benefits for the deceased named below; and
2. I authorize the insurance company(ies) underwriting the policy, its representatives or business associates assisting in the processing of the claim, to disclose the claims information submitted to the insurance company(ies), its representatives or business associates assisting in the processing of the claim, to any insurance support organization or fraud information clearinghouse utilized by the insurance company(ies), or its representatives or business associates. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for a period not to exceed one year from the date signed. I understand I have the right to receive a copy of this authorization and that I may revoke this authorization at any time for information not then obtained upon providing written notice of such revocation of the authorization to the insurance company(ies) underwriting the policy, its representatives or business associates assisting in the processing of the claim.

Signature of claimant: _____ Date: _____

Please send completed form and supporting documents to
Email: GBGclaims@cbpinsure.com **Fax: 866-616-0444**
Mail: Co-ordinated Benefit Plans, LLC on Behalf of Global Benefits Group
PO Box 2069
Fairhope AL 36532

For claim status:
U.S./Canada toll-free: 866-669-9004
Local: 251-928-0939
Email: GBGclaims@cbpinsure.com