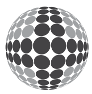

COLINA

Colina Insurance Limited
P.O. Box N4728
Nassau, The Bahamas

TRAVEL INSURANCE CLAIM FORM

ONLY COMPLETE THIS FORM IF YOU TEST POSITIVE WITH A COVID-19 PCR TEST WHILE IN THE BAHAMAS
Please complete ALL sections of this form (two pages), sign and date it, and send it to Colina Insurance Limited. This form, along with the supporting documents, must be received within 90 days of the date of your positive COVID-19 PCR test. A delay in processing the claim will occur if an incomplete form or unacceptable proof of loss is submitted. Forms can be returned via:

- E-mail to **Travelclaim@colina.com** or
- Fax to **242-393-8773**

The following documentation must also be submitted where applicable:

- Positive COVID-19 PCR test results;
- Airline ticket, itinerary or boarding pass showing arrival and departure dates and proof of payment;
- Lodging and meal receipts
- Detailed medical bills/invoices; and
- Receipt(s) for payment of medical expenses

SECTION A - General Information

Primary Insured

Title | Last Name | First Name | Middle Initial | Maiden Name

Address

No. / Street | City | State / Province / Island | Zip/Postal Code

Telephone Numbers

Residence | Business | Cell | Fax

Email Address

Gender
☐ Male ☐ Female

Traveler ID No.

Trip ID No.

Date of Positive PCR test
Day | Month | Year

Arrival Date
Day | Month | Year

Departure Date
Day | Month | Year

SECTION B - Additional Travellers

Please list any additional travellers in your party with whom you shared accommodations:

Last Name	First Name	Initial	
			☐
			☐
			☐
			☐

Did any travellers in your party also have a positive COVID-19 PCR test? ☐ Yes ☐ No

Please indicate which ones by ticking ☐ next to their name above.

SECTION C - Other Coverage

Do you have any other insurance that may provide benefits for this loss ☐ Yes ☐ No

If you answered "Yes" to the above, please provide the following:

Name of Insurance Company	Policy/Certificate Number	Telephone Number & Website

SECTION D - Claim Reimbursement & Assignment Information

If claim is being submitted for a child under the age of 18, please provide the name of a relative to whom payment should be made:

Relative

Title	Last Name	First Name	Middle Initial	Relationship

Address if different from above

No. / Street	City	State / Province / Island	Zip/Postal Code

If benefits are being assigned, please provide the name of the assignee and the dollar amount of benefits being assigned.

Name of Assignee	Amount Assigned ($)

SECTION E - Electronic Funds Transfer Authorization

Bank Name

Name on Account (Beneficiary)

Bank Address

No. / Street	City	State / Province / Island	Zip/Postal Code

Bank Account Number

Account Type
☐ Savings
☐ Chequing

ABA Routing Number

IBAN

SWIFT Code

Are you currently collecting VAT? ☐ Yes ☐ No If yes, please provide VAT TIN#

SECTION F - Declaration & Authorization

By signing below, I certify that the information stated above is true and correct and authorize Colina Insurance Limited to execute the Electronic Funds Transfer for reimbursement of benefits payable in accordance with the Schedule of Benefits. I understand and acknowledge that the benefit payable may be reduced by fees charged by the recipient's bank.

I hereby certify that the above is a true statement of the travel expenses incurred by me in accordance with the Travel Insurance Program. I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, the Medical Information Bureau Inc., or insurance company to give to Colina Insurance Limited, or its legal representative, any and all such information necessary to evaluate this claims for payment of benefits.

Insured or Authorized Person

Print name	Signature

Date

Day	Month	Year