# UHM STUDY ABROAD CENTER INSURANCE PLAN

All UHM Study Abroad Program Participants are required to take the Center's Mandatory Health Insurance Plan, if not already covered with a program-based plan. The cost of the health insurance is calculated at $1.00 per day for the duration of the program overseas, beginning from the departure date until the date of return. The insurance plan is administered by T.W. Lord & Associates.

**The Insurance Plan covers the following:**

1. Accidental Death and Dismemberment, up to $15,000.
2. Medical or Surgical Expenses after a deductible of $50 per accident or illness, 100% of the first $5,000, 80% of the next $5,000 and 100% thereafter, to a maximum of $500,000. There are exclusions.
3. Emergency Medical Evacuation (approved by a physician) up to the maximum of $100,000.
4. Repatriation of Remains for a maximum of $25,000.
5. Emergency Dental Expense Benefit for a maximum of $25,000.
6. Family Assistance Benefit: If an insured person requires hospitalization exceeding seven days, the insurance will cover the round-trip airfare and up to $100 per day for lodging expenses for a family member to provide assistance.
7. Reunification Benefit: If one of the insured person's immediate family members dies while the student is abroad, the insurance will pay up to $1,000 toward the cost of airfare for the student to return for a visit home.
8. Post Program Coverage: Benefits will be paid up to $10,000 for expenses incurred in the United States for the accidents or illnesses which were first treated while participating in the UHM Study Abroad Program. These expenses must be incurred within 60 days after return to the U.S.
9. Pre-existing Condition Benefit up to a maximum of $2,500.
10. Worldwide Travel Assistance

**For Claims and Reimbursement and Detailed Information Concerning the Policy:**

TW Lord and Associates
Tel: 770-427-2461
Toll-free: 800-633-2360
*claims@twlord.com*

Referral Assistance Worldwide from within U.S./Canada:
800-243-6124
Referral Assistance Worldwide from outside U.S./Canada:
international collect 202-331-1596

**Referral Assistance Worldwide**

Included in the health insurance program is access to the 24-hour Worldwide Assistance network for emergency assistance anywhere in the world. In case of emergency, call the number listed above. The multilingual staff will answer your call in English and immediately provide reliable, professional, and thorough assistance.

The following services are included in the program:

1. Referral to the nearest, most appropriate medical facility, and/or provider
2. Medical monitoring by board-certified emergency physicians in the United States
3. Urgent message relay between family, friends, personal physician, school, and insured.
4. Guarantee of payment to provider and assistance in coordinating insurance benefits.
5. Arranging and coordinating emergency medical evacuations (with the approval of a physician) and repatriation of remains
6. Emergency travel arrangements for disrupted travel as the consequence of a medical emergency
7. Referral to legal assistance
8. Assistance in locating lost or stolen items including lost ticket application processing. These services are included in the insurance provided in this program.

**KEEP THIS SHEET—FOR YOUR INFORMATION**

# UHM STUDY ABROAD CENTER INSURANCE PLAN
# HEALTH, EMERGENCY, EVACUATION, REPATRIATION & TRAVEL ASSISTANCE INSURANCE
## UHM Study Abroad Center

(provided as a service for individual UHM Faculty/Staff not participating in a UHMSAC program)

**INSURANCE APPLICATION**

PRINT THE FOLLOWING INFORMATION

**Applicant**

| *name* | *email* | *date of birth* |
|---|---|---|
| *mailing address* | | *UHM ID* |

**Location Abroad**

| *(list cities and countries)* |
|---|

**Dates Abroad**

| *departure date from U.S* | *return date from abroad* | *Total number of days* |
|---|---|---|

**Overseas Activity Sponsor**

| *(Departmental Contact Info.)* |
|---|

UHM Study Abroad Center insurance is provided by TW Lord & Associates and at a rate of $1/day. Count the departure from the U.S. as the first day and the return date as the last day.

**Attach a check for the total amount of days payable to TW Lord & Associates.**

Notes— Insurance applications are subject to final approval by the Study Abroad Center for coverage. Coverage is in effect only while the applicant is outside the U.S.

# UNITED STATES FIRE INSURANCE COMPANY

**By Fairmont Specialty, a Division of Crum & Forster**
**Eatontown, New Jersey**

**Claim Instructions**
*Attach itemized bills, showing treatment, and dates of treatment and charges to the claim form, forward additional bills to the above address.*Do not leave claim form at hospital.*Payment Will be made to the doctor or hospital, etc., unless a paid receipt or statement is attached.* No additional claim form is necessary.

## MAIL TO:

**T.W. LORD & ASSOCIATES**
**P.O. BOX 1185**
**MARIETTA, GA 30061**
**PHONE 1-800-633-2360**

**It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/ or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.**

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**To Be Completed By Claimant** **SOCIAL SECURITY NUMBER** ___-___-___

Claimant's Name_____Date of Birth_____Male_____Female_____
Last Name First Name

Present Address_____
No. & Street City or Town State Zip

Geographical Location_____Phone Number_____email address_____

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Date of accident or sickness

_____

Nature of sickness or injury

_____

If injury, describe fully how and where accident occurred

If Injured in Play or Practice of Sport
Indicate What Sport
Check One: ____Intramural ___ Inter Collegiate____Club

_____

Have you ever had the same or similar symptoms ___ Yes ___ No If so, when?

Were you treated at the Student Health Services?
_____Yes
_____No If so, When?

_____

Name and Address of Physician

_____

Give names of all other Physicians consulted

_____

Hospitalized From: To:

_____

Name and Address of Hospital

_____

Are you covered by any other medical insurance policy? Yes_____ No_____ if Yes, Please provide name and address of other Insurance Company.

_____Policy Number:_____

_____

**AUTHORIZATION TO OBTAIN MEDICAL INFORMATION**

TO: Any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder or benefit plan administrator.

I AUTHORIZE you to release to the UNITED STATES FIRE INSURANCE COMPANY or its representatives, PROFESSIONAL CLAIMS ADMINISTRATORS, INC. any and all information concerning advice, care or treatment provided the patient, or deceased, including information relating to mental illness, use of drugs or use of alcohol. I also authorize the group policyholder or benefits plan administrator to provide to the UNITED STATES FIRE INSURANCE COMPANY or its representatives, PROFESSIONAL CLAIMS ADMINISTRATORS, INC. with insurance coverage information including benefits paid or payable, financial information or employment related information. I UNDERSTAND that the information released under this authorization will be used for the purpose of evaluating and processing a claim for benefits. I authorize the UNITED STATES FIRE INSURANCE COMPANY, or its representatives, PROFESSIONAL CLAIMS ADMINISTRATORS, INC. to disclose the information for that purpose to the group policyholder or its representatives, to any reinsurer, and to any other insurer or self-insurer to whom a claim for benefits may be submitted. This disclosure will include benefits paid or copies of checks/drafts.

I also AUTHORIZE the UNITED STATES FIRE INSURANCE COMPANY, or its representatives, PROFESSIONAL CLAIMS ADMINISTRATORS, INC. to disclose the information to any person performing a business or legal function for its benefit, and to any person who has an authorization specifically permitting the disclosure.

I AGREE that the authorization shall be valid from the date signed for one full year.

I know that I have a right to request to receive a copy of this authorization. A photocopy of this authorization shall be as valid as the original.

_____ _____
**Signature of Patient** **Date Signed**