

PROOF OF LOSS

Mail to:

Co-ordinated Benefit Plans, Inc.
P.O. Box 26222
Tampa, FL 33623-6222
(888) 753-1000 / Fax (727) 799-9093

Insurance Carrier: Virginia Surety Company, Inc.
Program Reference # _____
Group Name: _____
ID Number: _____

PERSONAL LIABILITY CLAIM FORM

Instructions:

- 1.) This form is to be used when filing a claim for Personal Liability and must be completed by the Insured in full.
- 2.) This form must be signed and dated in all applicable sections. In some cases, two signatures are required (minor dependent).
- 3.) **Please mail the completed form to the above address, along with proof of coverage and any reports pertaining to this incident.**

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract. Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

Coverage Effective Date ___/___/___ Coverage Termination Date ___/___/___ E-mail address: _____

1.) Name of Insured: _____ Date of Birth ___/___/___ Sex: ___ Male ___ Female

2.) Name of Claimant: _____ Date of Birth ___/___/___ Sex: ___ Male ___ Female

3.) Current Residence Address: _____

4.) Daytime Phone Number: (_____) _____

5.) Date of Arrival in U.S.: ___/___/___ Date scheduled to return to Home Country: ___/___/___

6.) Permanent Address (In Home Country): _____

7.) Name of Program: _____ Are you currently still enrolled in this program? Yes _____ No _____

8.) Date of Incident: _____ Location of Incident: _____ Police/Security Notified: Yes _____ No _____

9.) Description of Incident: _____

10.) Extent of Damage/Injury: _____

11.) Name(s) and Address(es) of Witness(es): _____

12.) Person to contact for additional information: _____ Phone Number (_____) _____

I hereby certify that the above information is true and correct to the best of my knowledge and belief.

Signature

Date

Signature of Claimant or Parent, If Claimant is a Minor

Date

State Fraud Notices— **For Use On Applications and Claims Forms**

(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.

(Missouri) An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

(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.