

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 or Claims Administrator. 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 or Claims Administrator to approve these services will result in the complete denial of benefits.

Submit this completed form along with:

- Approval from the Assistance Provider or Claims Administrator
- Billing Statement and Proof of Payment 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? <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of company: | | |

CLAIM INFORMATION

| | | |
|--|---------------------------|----------------|
| Assistance Company/Claims Administrator Approval Number | Date Approved: | |
| Cause of Death | | |
| Date of Death: | State and County of Death | |
| Was the Member Hospitalized: <input type="checkbox"/> Yes From: _____ To: _____ <input type="checkbox"/> No | | |
| Name of Funeral Service Provider: | | |
| Cost of Local Burial | Invoice # | Amount Claimed |
| Family Member providing information (Claimant) | | |
| Address | | |
| Relationship to member | Phone Number | |

SELECT ONE FORM OF REIMBURSEMENT

| | | |
|---|----------------|---|
| Payment to – Check one: <input type="checkbox"/> Family Member (must provide receipt) <input type="checkbox"/> Funeral Service Provider Payment | | |
| <input type="checkbox"/> Send a check to mailing address: | Street Address | City |
| | State | Zip Code |
| – OR – | | |
| <input type="checkbox"/> Send by Electronic Direct Deposit (fill all fields): | Bank Name | Name on Account |
| | Account #/IBAN | Routing #/ABA # (for Electronic Direct Deposit) |

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 |
|-----------------------|------|

CLAIM FORM FRAUD STATEMENT - FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARIZONA For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ALASKA A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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

COLORADO It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

KANSAS Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

KENTUCKY Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

MARYLAND Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW HAMPSHIRE Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20

NEW JERSEY Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO 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.

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.

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.

OHIO Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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

TEXAS Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Economic or Trade Sanctions: Any payments under this policy will only be made in full compliance with all United States of America economic or trade sanction laws or regulations, including, but not limited to, sanctions, laws, and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC"). Therefore, any expenses incurred, or claims made involving travel that is in violation of such sanctions, laws and regulations will not be covered under this policy. For more information, You may consult the OFAC internet website at <https://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx>.

Electronic Communication: 1. Consent to receive insurance related documents and communications, including but not limited to, your policy documents, disclosures, notices, explanation of benefits (EOB), claims documentation, as well as termination and cancellation or non-renewal notices, electronically to the email address you provide to us through the online application process instead of receiving these records in a paper format from us. 2. Agree and acknowledge that your consent is provided and/or obtained in connection with a transaction affecting interstate commerce subject to the Electronic Signatures in Global and National Commerce Act and the Uniform Electronic Transactions Act, or a similar electronic transactions law, as adopted by state law. 3. Agree that the document(s) delivered to you electronically shall have the same meaning and effect as if you were provided a paper document, whether or not you choose to view the document(s), unless you previously withdrew your consent to receive documents via electronic means as provided below. Electronic document(s) are considered received by you at the time you complete your purchase, unless we receive notice that the email notification was not delivered to you at the email address you provided.

Fraud Warning: If the Covered Person or any person acting on his/her behalf shall make any claim or statement knowing the same to be false or fraudulent as regards to amount or otherwise, then this Insurance shall become void and all claims here under shall be forfeited without refund of premium.

MAILING INSTRUCTIONS

Attention: Surego Administration on Behalf of Crum and Forster Insurance Company
PO Box 2069
Fairhope AL, 36533

Email: claims@mysurego.com