PROOF OF LOSS

Mail to:

Co-ordinated Benefit Plans, Inc.

P.O. Box 26222 Tampa, FL 33623-6222 Fax (800) 560-6340

or e-mail to: Team1@cbpinsure.com

Insurance Car	rier: Llo	yd's of London	
Program Refer	rence #		
Group Name:	Intrax		
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 Ho	ome Country://
6.) Permanent Address (In Home Country):	
7.) Name of Program: Are you o	
8.) Date of Incident: Location of Incident:	Police/Security Notified: Yes No
9.) Description of Incident (include additional pages if necessary):	
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 beliet.
0'	- Data
Signature	Date
Signature of Claimant or Parent, If Claimant is a Minor	Date