CG | UNITED

TRAVEL REIMBURSEMENT FORM

Health Insurance

Please email this completed form with the appropriate itemised receipts to Medical_Claims_BB@cgcoralisle.com within 90 days of travel to be eligible for reimbursement.

Additional forms are available to download from Resources on www.CGCoralisle.com.

PART 1 GENERAL INFORMATION

Patient's Surname ____________________ First Name ____________________ Initials ______

Certificate No. ____________________ Date of Birth (DD/MM/YY) ____________________

Relationship to Primary Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ____________________

Primary Insured's Surname ____________________ First Name ____________________ Initials ______

Mailing Address ____________________

Home Phone ____________________ Work Phone ____________________ Cell Phone ____________________

Email (Work) ____________________ (Home) ____________________

PART 2 TRAVEL DETAILS

Destination ____________________ Departure Date (DD/MM/YY) ____________________

Additional Traveller ____________________ Return Date (DD/MM/YY) ____________________

PART 3 REIMBURSABLE EXPENSES

AIRFARE

Airline ____________________ Patient Airfare __________ Companion Airfare __________ Currency ______

LODGING

Hotel Name ____________________ Length of Stay ____ Nights Total Charge __________ Currency ______

TRANSPORT AND FOOD

Car Rental Agency ____________________ Length of Rental ____ Days Total Charge __________ Currency ______

Taxi Expenses Total Charge __________ Currency ______

Food Expenses Total Charge __________ Currency ______

PART 4 DECLARATION

I hereby certify that the above is a true statement of the travel expenses incurred by me in accordance with the CG United Insurance Ltd. authorisation for travel.

Signature ____________________ Date ____________________

CG United Insurance Ltd.
Administered by Coralisle Medical Insurance Company Ltd.
www.CGUnited.com
Members of Coralisle Group Ltd.

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