CG | INSURANCE

TRAVEL REIMBURSEMENT FORM

Premier Health

Please complete this form and enclose the appropriate itemised receipts. Do not staple receipts to the form. Mail, fax or email this form (see contact details below) with receipts 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 Coralisle authorisation for travel.

Signature _____ Date _____

Coralisle Medical Insurance Company Ltd. Jardine House, 33-35 Reid Street, Hamilton HM 12, Bermuda
PO Box HM 1559, Hamilton HM FX, Bermuda | Tel 441 296 3200 | Fax 441 295 9036 | www.CGCoralisle.com

Health Insurance and Employee Benefits

INSURANCE | HEALTH | PENSIONS | LIFE

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