GEBA BENEFITS

Please return completed form to:
1362 Mellon Road, #100
Hanover, MD 21076
Fax: (410) 846-6420
Email: geba@geba.com
Phone: (410) 657-8060

Member Number
(if unknown, leave blank)

Call us with questions:
(410) 657-8060 or (800) 826-1126

Emergency Travel Plan (ETP) Claim Form

Instructions:

- Claim must be submitted within 90 days of the eligible travel event.
- Travel must begin within 21 days of the injury, illness, or death.
- Please print legibly or type and complete ALL requested information on this claim form.
- If the claim is submitted within 12 months of the coverage effective date, and/or travel is due to an illness or accident, please include the Physician's Statement (available at GEBA.com/forms) with the claim form.
- If travel was due to a death, attach a copy of the death certificate.
- Documentation of travel, including costs, is required. You must either include your original ticket, and the electronic ticket or some form of documentation reflecting the names of the travelers, dates of travel, destination of travel, and ticket prices. GEBA will reimburse up to 80% of travel up to $1,500 per person and 80% of checked baggage fees for 1 bag per person each way. Please include receipt of the checked baggage fees paid. If your ticket was purchased with foreign currency, please specify and provide the exchange rate on the date of purchase.
- Travel must be completed prior to filing a claim.
- Reimbursements will be made directly to the member for 1 round-trip per person.

Member Information:

Member's Name (First, MI, Last)

Date of Birth (mm/dd/yyyy)

Address Line 1

Email Address

Address Line 2

City

State

Zip Code

Home Phone

Cell Phone

Office Phone

Claimant Information:

Please list each claimant separately. Please attach another sheet of paper if you have additional claimants.

Claimant Name: ☐ Member ☐ Spouse/Domestic Partner ☐ Dependent

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Travel Information:

Reason for Travel: ☐ Serious Illness ☐ Serious Injury ☐ Death

Name of Family Member Visited:

Relationship to Member:

Date of Illness/Injury/Death:

Nature of Illness/Injury/Death:

Date of Hospitalization:

Attending Physician's Name:

Physician's Address:

Hospital Name and Address:

Travel Itinerary:

Departure:		Return:	
Date:		Date:	
Airline/Rail Name:		Airline/Rail Name:	
Depart From:		Depart From:	
Arrive At:		Arrive At:	

Total Fares/Fees:

Total fare as appears on attached documentation: $

Total checked baggage fees (1 per person each way with receipt): $

Is this foreign currency? ◯ Yes ◯ No

If yes, please list currency type and USD conversion rate on day of purchase:

Was a travel voucher used toward the purchase of this fare, or has any portion of this fare been refunded or reimbursed? ◯ Yes ◯ No

If yes, amount refunded: $

For which claimant(s):

Signature:

I have attached the following necessary documentation:

☐ Airline/train ticket confirmation or official travel agency documentation signed by agent

☐ Certified copy of death certificate (if traveling due to a death)

☐ Attending Physician's Statement (if travel is within 12 months of coverage effective date, or due to a serious illness or injury)

I request benefits for these expenses and certify that the above information is complete and true to the best of my knowledge and belief. I understand that any misrepresentation contained herein may be used to reduce or deny this claim. I also understand that any intention to defraud or knowingly facilitate fraud against GEBA, by submitting a false or deceptive statement is insurance fraud.

Signature: _____ Date: