COLONIAL

PremierHealth

TRAVEL REIMBURSEMENT FORM

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 www.cgigroup.bm.

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) _____

TRAVEL DETAILS

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

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

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 _____

DECLARATION

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

Signature _____ Date _____

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