DAN Claim Form

Integrated claim form + Notice of Insurance

Please complete all applicable sections. Incomplete forms may delay processing.
For mobile completion, tap each field or checkbox. Attach supporting documents when submitting.

1. Member Information

Insured Member Full Name

DAN Member ID

Date of Birth

Home Address

City

State/Province

Postal Code

Country

Phone

Email

Relationship to Insured

2. Other Insurance Information

Do you have health insurance and/or travel insurance other than DAN?
ex: BCBS, Aetna, Cigna, Travelex, Allianz, AXA, Faye, etc.

○ Yes ○ No

Insurance Company

Policy Number

Phone

Type of Other Coverage - check all that apply - if more than one, please list in other

☐ Health Insurance ☐ Travel Insurance ☐ Medicare / Supplement

☐ Tricare ☐ Medicaid ☐ Workers Compensation

☐ Accident Insurance ☐ Other If Other, describe

3. Notice of Insurance / No Other Insurance Affidavit

I confirm that neither I, nor any party affiliated with me (including my employer), has any other insurance, contract, or agreement that would pay all or any portion of the charges incurred as a result of the injury or illness for which this claim is submitted, except as disclosed in this form.
I understand that DAN coverage is supplemental or excess coverage except where the only other coverage is Medicare, Medicare Supplement, Tricare, or Medicaid, as applicable under the policy.
I understand that failure to disclose other insurance may constitute fraud and may invalidate coverage.

Check only if you have NO other applicable insurance to disclose.

☐ I certify this affidavit is true.

4. Claim Type and Incident Details

Claim Type ○ Dive accident ○ Named Water Sport ○ Non-Dive Accident ○ Other

Date of Incident / Loss

Location of Incident

Country

Was this claim work-related? ○ Yes ○ No

Workers Compensation filed? ○ Yes ○ No

Describe the incident / injury / illness in detail

5. Dive-Specific Information (complete if applicable)

Dive depth

Bottom time

Number of dives that day

Gas used

Dive computer available? ○ Yes ○ No

Symptoms experienced

6. Medical Treatment

Date first seen by doctor

First treating physician / provider

Hospitalized? ○ Yes ○ No

Hospital / Facility Name

Hospital / Facility Phone

Dates admitted / discharged

Hospital / Facility Address

7. Additional Carrier / Third-Party Information

Have you submitted or will you submit this claim to any other insurer or benefit plan? ○ Yes ○ No

Carrier / Plan Name

Claim Number

Benefit determination received? ○ Yes ○ No

Have you filed or will you file against another party for damages related to this incident? ○ Yes ○ No

If yes, provide details

8. Required Supporting Documents Checklist

- ☐ Attach itemized medical bills
- ☐ Attach payment receipts for out-of-pocket expenses
- ☐ Attach medical reports / diagnosis
- ☐ Attach copy of other insurance ID card(s), if applicable
- ☐ Attach EOB or denial from other insurer, if applicable
- ☐ Attach additional pages if more space is needed

9. Authorization and Certification

I authorize any insurance company, employer, hospital, physician, or other provider to release information that may have a bearing on benefits payable under this claim or any related plan.
I certify that the information provided in this form is true and complete to the best of my knowledge.

Insured Member Signature

Patient Signature (if not insured member)

Date

Authorize payment of benefits directly to provider, if applicable: ☐ Yes, I authorize assignment of benefits

If you choose to pay the provider directly, you must submit proof of payment with your claim. If proof of payment is not provided, DAN and/or its underwriters reserve the right to issue payment directly to the provider for any eligible expenses.

10. Submission Instructions

- Email completed form and supporting documents to claims@dan.org, or mail to DAN Claims, 6 West Colony Place, Durham NC 27705 USA.
- For treatment in the USA, providers should submit claims with a UB04 or CMS 1500 when applicable and include your DAN Member ID.
- For treatment outside the USA, submit itemized bills, medical reports with diagnosis, receipts, and any other insurer benefit determination.