PROOF OF LOSS - TRIP CANCELLATION/INTERRUPTION/DELAY

Global Claims Administration
3195 Linwood Rd, Suite 201
Cincinnati, OH 45208
800-513-2981 513-533-1330

NAME OF GROUP:

POLICY NUMBER:

TRIP CANCELLATION/INTERRUPTION/DELAY CLAIM FORM

INSTRUCTIONS:

TRIP CANCELLATION/INTERRUPTION

1.) SECTIONS A AND B MUST BE COMPLETED FULLY BY CLAIMANT.
2.) SECTION D MUST BE SIGNED BY CLAIMANT.
3.) SECTION C MUST BE COMPLETED FULLY BY ATTENDING PHYSICIAN.
4.) ATTACH COPY OF CREDIT CARD STATEMENT (IF APPLICABLE) AND/OR RECEIPTS AND CORRESPONDENCE PERTAINING TO LOSS.
5.) PROVIDE ORIGINAL/UNUSED AIRLINE TICKETS.
6.) DIRECT ALL CORRESPONDENCE TO CLAIM OFFICE SHOWN ABOVE.

INSTRUCTIONS:

TRIP DELAY

1.) SECTIONS A AND D MUST BE COMPLETED FULLY BY CLAIMANT.
2.) SECTION D MUST BE SIGNED BY CLAIMANT.
3.) ATTACH COPY OF CREDIT CARD STATEMENT (IF APPLICABLE) AND/OR RECEIPTS SHOWING CHARGES MADE FOR TRIP AND ALL CORRESPONDENCE PERTAINING TO LOSS, INCLUDING VERIFICATION FROM COMMON CARRIER OF DELAY AND RECEIPTS OF EXPENSES INCURRED DUE TO DELAY FOR FOOD AND LODGING.
4.) DIRECT ALL CORRESPONDENCE TO THE CLAIM OFFICE SHOWN ABOVE.

THE FURNISHING OF THIS FORM, OR ITS ACCEPTANCE BY THE COMPANY, MUST NOT BE CONSTRUED AS AN ADMISSION OF ANY LIABILITY ON THE COMPANY, NOR A WAIVER OF ANY OF THE CONDITIONS OF THE INSURANCE CONTRACT.

SECTION A

CLAIMANT NAME:	DATE OF BIRTH:	SEX: ☐ MALE ☐ FEMALE	
ADDRESS	CITY	STATE	ZIP

DAYTIME PHONE NUMBER: ( )

DO YOU CARRY ANY OTHER INSURANCE THAT WOULD APPLY TO THIS LOSS: YES ☐ NO ☐
IF YES, GIVE NAME OF COMPANY, POLICY NUMBER, TYPE OF POLICY AND AMOUNT.

SECTION B

NAME, ADDRESS AND PHONE NUMBER OF TOUR OPERATOR /TRAVEL AGENT

NAME OF AIRLINE (OR OTHER) TRANSPORT	SCHEDULED DATE OF DEPARTURE	SCHEDULED DATE OF RETURN

AMOUNT OF FARE: $	LAND ACCOMMODATION: $	TOTAL: $
AMOUNT PAID: $	AMOUNT REFUNDED: $	AMOUNT OF CLAIM: $

DATE OF INTERRUPTION/CANCELLATION AND REIMBURSEMENT REQUEST:

WAS SUBSTITUTE TRANSPORTATION ARRANGED? YES ☐ NO ☐	IF YES, ADVISE: DATES & PLACE OF DEPARTURE:	DATES & PLACE OF ARRIVAL:

WILL YOU BE REIMBURSED FROM ANY OTHER SOURCE FOR ANY PORTION OF FARE PAID? YES ☐ NO ☐	IF YES, AMOUNT OF REIMBURSEMENT: $

NAME OF PERSON HAVING SICKNESS OR INJURY:	HIS/HER RELATIONSHIP TO YOU:
DATE SICKNESS OR INJURY BEGAN:	DATE ENDED:

NATURE OF SICKNESS OR INJURY (IF INJURY, DESCRIBE ACCIDENT, INCLUDING DATE AND PLACE):

DATE OF FIRST TREATMENT:	IF HOSPITALIZED, DATES CONFINED: FROM TO

FULL NAME ADDRESS AND PHONE NUMBER OF PATIENT'S REGULAR PHYSICIAN:

*FULL NAME AND ADDRESS OF ANY OTHER PHYSICIANS(S) OR MEDICAL SUPPLIERS FROM WHOM TREATMENT WAS RECEIVED:

*IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL(S) FROM WHOM TREATMENT WAS RECEIVED:

FAILURE TO PROVIDE THESE NAMES AND ADDRESSES MAY CAUSE UNNECESSARY DELAY IN THE PROCESSING OF YOUR CLAIM.

SECTION C

THE ATTENDING PHYSICIAN'S STATEMENT BELOW MUST BE COMPLETED BY THE ATTENDING PHYSICIAN (MUST NOT BE COMPLETED BY A PHYSICIAN WHO IS A FAMILY MEMBER OF THE CLAIMANT OR PATIENT)

NAME OF PATIENT: AGE OF PATIENT:

NATURE OF SICKNESS OR INJURY:

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT OCCURRED:

DATE OF FIRST TREATMENT: WAS PATIENT TREATED BY SOMEONE ELSE?

IF SO, BY WHOM? WHEN?

(IF APPLICABLE) WAS PATIENT DISABLED FROM TRAVEL AS A RESULT OF THIS SICKNESS/INJURY? YES ☐ NO ☐

IF SO, FOR HOW LONG?

HAS THE PATIENT RECEIVED MEDICATION OR OTHER TREATMENT FOR THIS CONDITION, OR FOR A RELATED CONDITION BY YOU OR ANY OTHER PHYSICIAN PREVIOUSLY? YES ☐ NO ☐

IF YES, PROVIDE EXACT DATES AND DETAILS:

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

PHYSICIAN'S SIGNATURE: _____ DATE: _____

NAME OF PHYSICIAN (TYPE OR PRINT): _____

ADDRESS OF PHYSICIAN: _____

TAXPAYER IDENTIFICATION NUMBER: _____ TELEPHONE NUMBER: (_____) _____

SECTION D

DATE OF DEPARTURE:

DATE OF DELAY:

EXPLAIN CAUSE OF DELAY (*VERIFICATION FROM CARRIER MUST BE INCLUDED*):

AMOUNT CLAIMED (*RECEIPTS MUST BE INCLUDED*):

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

For claimants not residing in California, New York, or Pennsylvania: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE OF CLAIMANT OR PATIENT, IF OTHER THAN CLAIMANT DATE