PROOF OF LOSS - TRIP CANCELLATION / INTERRUPTION / DELAY

Global CLAIMS ADMINISTRATION

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.

For the Quarantine Benefit for Trip Delay, you must provide all of the following:

- A positive COVID test result
- Proof you were ordered to quarantine
- Proof of a scheduled trip, and
- Proof of "reasonable accommodation, meal and local transportation expenses".

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

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW: 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

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KANSAS: A "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

KENTUCKY:
Application: 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 commits a fraudulent insurance act, which is a crime.
Claim Form: 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.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY:
Application: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
Claim Form: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

NEW MEXICO: 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 CIVIL FINES AND CRIMINAL PENALTIES.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON:
IMPORTANT NOTE: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefit.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NEW YORK FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

AUTHORIZATION: I hereby authorize Crum & Forster, United States Fire Insurance Company or its representative, to inspect or secure copies of case history records or any other data necessary to determine eligibility of benefits. I also authorize Crum & Forster, United States Fire Insurance Company or its representative to release and share claim information including that which may be used in the identification and prevention of potential fraudulent activity to any insurance organization, fraud information clearinghouses, designated service providers and business associates assisting in the processing of this claim. A photostatic copy or facsimile of this authorization shall be deemed as effective and valid as the original. This authorization is valid for twelve (12) months from date of signature. **I HAVE REVIEWED AND ACKNOWLEDGE THE ATTACHED FRAUD WARNING.**

SIGNATURE OF INSURED_____ DATE_____

PLEASE COMPLETE THIS FORM IN FULL AND RETURN TO GLOBAL CLAIMS ADMINISTRATION

Claims can be submitted by mail **OR** email to:

Global Claims Administration
3195 Linwood Avenue, Suite 201
Cincinnati, OH 45208

Claims@globalunderwriters.com *All attachments sent to the claims email must be in PDF format.