



Chubb Travel Protection Claim Form

Car Rental Collision Coverage

Instructions

When reporting the claim please provide your name, Policy ID number, type of claim, and preferred contact information. Once you have completely filled out the appropriate sections of the claim form, submit it to *Administrative Concepts, Inc.* (contact information below). In addition to the claim form, you may be required to provide other specific information. In order to expedite your claim, please provide the applicable documentation based on the coverage(s) you are claiming. A claim form should be completed for each policy issued.

Quick Reference Guide

Car Rental Collision Coverage

- Rental Agreement
- Estimate of damages
- Police report/accident report

Please email your completed claim form with legible documentation to:

Administrative Concepts, Inc.
994 Old Eagle School Road Suite 1005 Wayne, PA 19087-1802
Email: chubbtravel@acitpa.com



All Sections need to be completed for claims submissions.

I. General Information – please complete or provide a copy of your policy confirmation statement

Plan Purchased _____ Policy ID Number _____

Travel Company Name _____ Date of Booking _____

Trip Departure Date _____ Trip Return Date _____

Primary Insured Name _____ Primary Insured Date of Birth _____

Parent or Guardian Name if Primary Insured is under 18 _____

Home Phone # _____ Work Phone # _____

Please provide telephone numbers with country and city codes.

Mailing Address _____

Email Address _____

Preferred Contact Method _____

Reason for Claim:

II. Coverage Information

Do you have any other insurance? (i.e. car insurance) Yes No

If yes, please provide source of insurance _____

Are claim expenses recoverable for another source? _____

If yes, please provide details and amounts:

III. Payment Information (funds will be issued in U.S. currency)

Payment to Insured, Guardian or Beneficiary

Mailing address listed on page 2

Direct deposit to your checking account Direct deposit to your savings account

Name on Account _____

Bank Name _____ Bank Account Number _____

Bank Address _____ Bank Routing # or Swift Code _____

IBAN _____

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IV. Car Rental Collision Claim Information (see list of required documents on page 1)

Booking/Reservation #: _____ Rental Company: _____

Rental Company Address: _____

Rental Company Phone #: _____ Dates of Rental: _____

Name of person driving rental car: _____ Date of incident: _____

Car Pick Up Date: _____ Car Return Date: _____

Were the Police notified? Yes No

Was an accident report made to the rental agency? Yes No

Please describe how the loss/accident occurred:

Please describe any damage to the vehicle:

Was Car Rental Collision Coverage Purchased? Yes No

Your Auto Insurance Carrier: _____ Auto Policy #: _____

Auto Insurance Carrier Phone #: _____

If accident involved another vehicle, please provide the information below if obtained:

Other Driver 1 Name: _____ Other Driver 1 Auto Insurance: _____

Other Driver 1 Policy #: _____ Other Driver 1 Auto Insurance Phone #: _____

Other Driver 2 Name: _____ Other Driver 2 Auto Insurance: _____

Other Driver 2 Policy #: _____ Other Driver 2 Auto Insurance Phone #: _____

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V. Declaration *(if signing electronically, do not lock document until 3rd signature is complete)*

I declare that the information given is to the best of my knowledge and belief, full, true, and correct:

Signed _____ **Date** _____

Authorization and Assignment of Benefits

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 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 *agree* that a photographic copy of this Authorization shall be as valid as the original.

I understand that I or my authorized representative may request a copy of this authorization.

I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative _____

Relationship *(if other than Insured)* _____ **Date** _____

Mailing Address _____

Patient's Signature and Release (Parent or Guardian, if claim is for a minor), I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine claim payment.

Signature _____ **Date** _____

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Fraud Warning: Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalized fraud statement. We have adopted the fraud warning language prescribed by the District of Columbia as its standard fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications and enrollment forms.

District of Columbia Generic Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and / or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

The following states have required us to use state specific language as follows:

California

For your protection California law requires the following to appear on this form:

Any person who knowingly presents 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.

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.

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.

New York

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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Oklahoma

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

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.

Maryland/Oregon

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

Virginia

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 may have violated state law.

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