CHUBB

Chubb Travel Protection Claim Form

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

☐ **Trip Cancellation/Trip Interruption/Trip Delay/Missed Connection** *(complete Part A)*

Paid receipts for all of the following items:

The amount of the non-refundable amounts paid for the trip:

– Any cancellation charges

– Any prepaid, unused, non-refundable airfare and sea or land accommodations

– Any other reasonable additional trip expenses for travel, lodging, or scheduled events that are prepaid, unused, and non-refundable

– The cost of a one-way economy air and/or ground transportation ticket

Proof of covered reason for claim unless Cancel For Any Reason coverage was purchased and applies

If applicable, include Attending Physician Statement for the individual with medical condition and complete Part C: Medical Expense

☐ **Baggage & Personal Effects** *(complete Part B)*

Proof of purchase (receipts, credit card statements, etc.)

Police report/incident report

Lost luggage – must file a formal claim with the transportation provider and provide us with copies of all claim forms and proof that the transportation provider has paid its normal reimbursement for lost, stolen, or damaged luggage

☐ **Baggage Delay** *(complete Part B)*

Documentation of delay or misdirection of baggage by common carrier

Proof of purchase (receipts, credit card statements, etc.)

☐ **Medical Expense** *(complete Part C)*

An itemized bill from the treating physician

Prescription – receipt showing claimant's name and the cost of the medication

Attending Physician's Statement

☐ **Repatriation of Remains** *(complete Part C)*

Expense for embalming or cremation

The least costly coffin or receptacle adequate for transporting the remains

Cost to transport the body from place of loss to his/her home country

Escort Services: expense for one (1) family member or companion who is traveling with the covered person to join the covered person's body during the repatriation to the covered person's place of residence

☐ **Car Rental Collision Coverage** *(refer to CRCC Claim Form)*

☐ **Accidental Death & Dismemberment** *(refer to AD&D Claim Form)*

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

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All Sections need to be completed for claims submissions.

Complete the Part specific to benefit being claimed as listed on page 1.

If you have a covered medical reason, you must complete Part C and include an Attending Physician's Statement.

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_____

II. Coverage Information

Do you have any other insurance? (i.e. health or homeowners insurance) ☐ Yes ☐ No

If yes, please provide source of insurance _____

Are claim expenses recoverable for another source? _____

If yes, please provide details and amounts:

_____

_____

_____

_____

_____

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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 _____

IV. Claim Information *(complete the Part that applies to your claim)*

Part A. Trip Cancellation/Trip Interruption/Trip Delay/Missed Connection

☐ Trip Cancellation ☐ Trip Interruption ☐ Trip Delay ☐ Missed Connection

Date and time of incident _____ Date Trip Cancelled/Interrupted/Delayed _____

Reason for Claim:

_____

_____

_____

_____

Are all insureds listed on policy impacted? ☐ Yes ☐ No

If no, provide list of insureds impacted.

_____

_____

Was the cancellation/interruption a result of your own injury/sickness? ☐ Yes ☐ No

If yes, please complete Part C.

Was the cancellation/interruption a result of injury/sickness to a relative or person defined in the Policy? ☐ Yes ☐ No

If yes, please complete Part C.

Name _____ Relationship to you _____

Address _____

If claiming Trip Delay, how long was your delay? _____

Please provide all documentation supporting the reason for your Trip Cancellation/Interruption/Delay/Missed Connection.

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IV. Claim Information *(continued)*

Part A. Trip Cancellation/Trip Interruption/Trip Delay/Missed Connection *(continued)*

Chart of Claimed Expenses (Please provide receipts supporting the below expenses)

Type of Expense	Name of Individual Associated with Expense	Date of Expense	Receipts Attached	Expense Amount
			Total Sum Claimed	

Part B. Baggage & Personal Effects / Baggage Delay

☐ Baggage & Personal Effects ☐ Baggage Delay

Date of loss / damage / theft _____ Country where loss / damage / theft occurred _____

Details of loss / damage /theft:

_____

_____

_____

To whom was loss / damage / theft reported _____

If articles(s) lost/stolen, what steps were taken regarding recovery of article(s)? *(Provide any written evidence)*

_____

_____

_____

If article(s) damaged, please supply estimates for cost of repairs or a letter from a reputable dealer confirming irreparably damaged. *(Supply receipts: if not available, please supply replacement estimates/invoices.)*

_____

_____

_____

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IV. Claim Information *(continued)*

Part B. Baggage & Personal Effects / Baggage Delay *(continued)*

Is any property lost/damaged/stolen insured by another company? ☐ Yes ☐ No

If yes, please supply name, address, telephone number and policy number.

Please supply name, address, telephone number and policy numbers of homeowners/household contents insurers.

Have you ever had any previous claims on this type of insurance? ☐ Yes ☐ No

If yes, please supply details with relevant dates.

Particulars of Claim

Full Description of Each Item of Property Lost, Damaged, or Stolen	State to Whom Property Belonged	Date of Purchase	Original Purchase Price	Receipts/ Replacement Estimates Attached
			Total Sum Claimed	

Please ensure you provide receipts if possible or replacement estimates from a reputable retailer for items $150.00 or more. Please note, without a receipt provided items claimed over $150.00 will be reduced by 50% from the replacement cost estimate.

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IV. Claim Information *(continued)*

Part C. Medical Expense & Repatriation of Remains

Patient's Name _____ Date of Illness (first symptom) or injury _____

Relationship to Primary Insured _____

Diagnosis or nature of illness or injury:

_____

_____

If injury – please describe:

_____

_____

_____

Date first consulted for this condition _____

Hospital Confinement Date: From _____ To _____

Disability Dates **Total**: From _____ To _____ **Partial**: From _____ To _____

Place of Service _____

Treating Doctor(s) _____

Treating Doctor City, State _____

Primary Care Physician _____

Primary Care Physician City, State _____

Primary Care Physician Phone # _____

Include copy of Attending Physicians Statement with documentation.

Include copy of all itemized medical expenses.

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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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