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

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.
PO Box 4000; Collegeville, PA 19426
Email: chubbtravel@acitpa.com

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 – *please complete this section for Medical Expense or Baggage & Personal Effects claims*

Do you have any other insurance that may provide coverage for this claim? (i.e. health or homeowners insurance)
_______ Yes _______ No

If yes, please provide source of insurance ______________________

Are claim expenses recoverable from another source? _______ Yes _______ No

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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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 NOTICES

For all states not specified below: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act, which is a crime.

For residents of Arkansas: 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.

For residents of the District of Columbia: 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.

For residents of 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 IN THE THIRD DEGREE.

For residents of Kansas: 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 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.

For residents of Kentucky: 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.

For residents of Louisiana: 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.

For residents of 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 denial of insurance benefits.

For residents of 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.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of 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.

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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 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.**

For residents of 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.

For residents of Oklahoma: WARNING: 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.

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

For residents of 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.

For residents of Rhode Island and West Virginia: 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.

For residents of 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 or denial of insurance benefits.

For residents of Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

For residents of Virginia: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FLALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATE STATE LAW.

For residents of 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.

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