# USI Travel Insurance Select® - Trip Cancellation

## Claim Form & Claimant's Statement

## PARTICIPANT'S INFORMATION:

Account Name and Policy Number: _____

Name of participant (i.e. student): _____

Address:_____ City:_____ State:____ Zip Code:_____

Email Address: _____ Home Phone #:_____

Work Phone: _____ Cell #: _____

Address:_____ City:_____ State:_____ Zip Code:_____

## LEGAL GUARDIAN INFORMATION:

Full Name: _____

Mailing Address: _____

Relationship to Participant: _____

Home Phone: (_____) _____/_____ Cell #: (_____) _____

Email Address: _____

Signature of participant's legal guardian: _____
(*** Please note: your signature indicates you are the legal guardian of the participant and authorizes payment issuance to you***)

## TRAVEL SUPPLIER / PROVIDER INFORMATION:

If your trip arrangements were made through a Travel Agent – please provide the agent's information, if not – then provide the information as related to the cruise line, land operator or airline as applicable:

Company Name: _____ Address:_____

City:_____State:____ Zip:_____ Contact:_____ Phone #:_____

Date Travel Protection Plan was purchased:_____ Date of initial payment deposit: _____

Scheduled Date of Departure: _____ Scheduled Date of Return:_____

If not included in package, how was air travel arranged? _____

## LOSS INFORMATION:

After completing this section, attach copies of all travel documents (original airline tickets, hotel receipts, travel itinerary, tour cost, etc.) supporting penalties, nonrefundable charges incurred by you due to cancellation,

| Company name: (airline/hotel/cruise/travel agent/etc.) | Amount paid: | Amount of loss: (non-refundable amount) | Have you received reimbursement? | If so, from whom? | How much? |
|---|---|---|---|---|---|
| | $ | $ | Yes No | | $ |
| | $ | $ | Yes No | | $ |
| | $ | $ | Yes No | | $ |
| | $ | $ | Yes No | | $ |
| Total | $ | $ | | | $ |

## REASON FOR CANCELLATION:

Date Trip was cancelled with Travel Supplier: _____ Reason for Cancellation: _____

_____

## IF CANCELLATION IS DUE TO MEDICAL REASONS:

Name of person having sickness or injury: _____

His / Her date of birth: _____ His / Her relationship to claimant: _____

Date Sickness or Injury began: _____ Date ended: _____

Nature of Sickness or Injury (If Injury, describe accident, including date and place): _____

_____

_____

Period of hospitalization (If applicable): _____

### To Be Completed by the Attending Physician

Name of patient: _____ Name of Doctor: _____

Address: _____

Office Phone #: _____ Office Fax #: _____

Date of Birth: _____ Date symptoms first appeared or accident occurred: _____

Date of first treatment: _____ Was patient treated by someone else?: Yes No

Diagnosis: _____

If so, by whom? _____ When?: _____

If patient is the traveler, did you prohibit patient's traveling by air or otherwise due to this injury/illness?: Yes No

Has the patient received medication or other treatment for this condition, or for a related condition, by you or any other Physician during the 90 days immediately prior to the date the claimant purchased this protection plan (see page 1 for date of purchase)? If so, please provide exact dates and details:

_____

_____

Any false or misleading statements made in support of and resulting in the payment of a claim shall be subject to legal action for collection of damages to the insurance company against the person or persons making such false and / or misleading statement

Physician Name: _____ Physician's Signature: _____

Taxpayer ID: _____ Date Completed: _____

### Authorization For Release of Medical Information – To be Completed by Patient

I hereby authorize Fairmont Specialty or its representative, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, x-rays, and any other data necessary to determine eligibility of benefits. I also authorize Fairmont Specialty 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 support organization, fraud information clearinghouses, designated service providers and business associates assisting in the processing of this claim. A photo-static copy of 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

**Signature**: _____ Date: _____

(Signature of Person Suffering Illness or Injury or legally authorized representative)

## DOCUMENTATION REQUIREMENTS:

Depending upon the circumstance involved in the loss, one or more of the following items may be required to complete the processing of your claim. Please place a check by those items you have attached. We recommend you keep copies of any items submitted with this claim.

Copies of cancelled checks or credit card statements that shows all payments made for the trip with an invoice from your Travel Provider showing the total cost paid for the trip.

Proof of Cancellation/Refund from travel supplier

Airline Ticket Stub/Receipt (if applicable)

Police Report (if applicable)

Car Rental Agreement (if applicable)

Copies of reimbursement statements issued by an airline carrier, airport facility, car rental agency, travel agent, hotel/motel or other similar establishment or any other insurance company providing reimbursement to you for the loss.

Other (please describe):_____

Please advise if you wish to be contacted via e-mail or regular mail:_____

## OTHER INSURANCE / AUTHORIZATION:

Do you have any other type of insurance?_____

If so, please provide the Company Name and Address:_____

Type of Policy:_____ Policy #:_____ Contact:_____Phone:_____

**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_____

## MAILING INSTRUCTIONS:

Send this form and any accompanying documentation to:

Attention: Co-ordinated Benefit Plans, LLC
On Behalf of United States Fire Insurance Company
P.O. Box 26222
Tampa, FL 33623
Email to: TravelTeam@cbpinsure.com or FAX: 800-560-6340
Toll Free: 877-539-6442
Direct Dial: 727-450-8795

## IMPORTANT NOTICE

**Fraud Warning: Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.**

**Notice to Arizona Claimants: 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.**

**Notice to California Claimants: 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.**

**Notice to Colorado Claimants: It is unlawful to knowingly provide false, incomplete, or misleading 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.**

**Notice to District of Columbia Claimants: 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.**

**Notice to Hawaii Claimants: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.**

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

**Notice to Kentucky Claimants: 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.**

**Notice to Oklahoma Claimants: 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.**

**Notice to Pennsylvania Claimants: 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.**

**Notice to Texas Claimants: 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.**