

Trip Cancellation/Trip Interruption

Insured's Statement

(Please print – Attach separate sheet if additional space required)

INSURED INFORMATION

Insured's Name _____ Certificate #: _____

Insured's Address _____

Primary Phone No. _____ Secondary Phone No. _____

Insured's Email Address: _____

CLAIM INFORMATION

Date trip was booked ____/____/____ (MM/DD/YY)

Scheduled departure date ____/____/____ (MM/DD/YY)

Scheduled return date ____/____/____ (MM/DD/YY)

No. of travelers affected: _____

Please provide the specific circumstances which caused your trip cancellation or trip

interruption: _____

Date trip was cancelled/interrupted: ____/____/____ (MM/DD/YY)

Who was notified of the cancellation? (Please provide the name and phone number of travel

agent, airline, cruise line, tour operator, etc.,) _____

Have you applied for or been given credit or other arrangements as reimbursement for your

loss? (If yes, please provide details) _____

†Total amount you are claiming \$ _____

†Trip Interruption ONLY: Please itemize total of amount you are claiming:

Description	Date of Original Purchase:	Name of Airline/Cruise Line/Hotel/Tour Operator or Other Vendor	Date of Travel/Stay:	Original Purchase Price:	Pending/Received Credit or Vouchers:	Non-refundable Amount Claimed:

(†Attach a separate sheet if additional space is required)

If your claim is the result of sickness or injury to you, a family member, a traveling companion or a child caregiver, please complete the following:

Name of sick or injured person _____

*Relationship to you _____

Date sickness or injury began ____/____/____ (MM/DD/YY)

Date sickness or injury ceased ____/____/____ (MM/DD/YY)

Nature of sickness or injury (If injury, please provide date, time, place, and circumstances of accident) _____

Date of first treatment ___/___/___ (MM/DD/YY)

If hospitalized, dates confined ___/___/___ (MM/DD/YY) to ___/___/___ (MM/DD/YY)

Please list the names and addresses of all treating/consulting physicians or healthcare providers: (Include name, street address, city, state, zip and phone)

If hospitalized, please provide name and address of hospital(s) where treatment was received:

Was sickness or injury the sole cause of your trip cancellation or trip interruption? (If not, please provide details) _____

If your claim is the result of the death of a family member, traveling companion, or traveling companion's family member, please complete the following:

Name of deceased _____

*Relationship to you _____

Date of death ___/___/___ (MM/DD/YY) (Please attach a copy of death certificate)

CERTIFICATION OF NO OTHER INSURANCE

I, _____ hereby certify that I have no homeowner, renter or any other travel insurance covering this loss and further attest that I have not submitted a claim for this loss under any other policy.

Signed (Insured or authorized person) _____

Date ___/___/___ (MM/DD/YY)

AUTHORIZATION

(A signed authorization must be completed by the sick or injured person)

I authorize any insurance company, physician, hospital or other healthcare provider, any travel organization or agency, airline carrier, cruise line, tour operator, rental agency, hotel, motel or similar entity providing lodging on a rental/lease basis or any other person who may have knowledge regarding this claim to release any information requested regarding this claim and the loss reported. I understand this information will be used by Broadspire Services, Inc., a subsidiary of Crawford & Company, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Signed (≠Sick or injured person) _____

Date ___/___/___ (MM/DD/YY)

≠If sick or injured person is a minor, please provide signature of parent or legal guardian.

If your claim has already been initiated*, upload the completed and signed form to:
<https://myclaimsagentupload.crawco.com> using your claim number and last name

*Or by Mail to: Claim Benefit Services, P.O. Box 459084, Sunrise, FL 33345

*Or Fax to: 1-855-830-3728

*Please include a cover sheet or cover letter with Insured name and Claim number

If this is a new claim, not yet submitted, you may complete this form online using this URL:
<https://myclaimsagent.com/EFTravelerLogin>

PLEASE NOTE: Any fees associated with the completion of this form and/or medical records requests remain the responsibility of the patient, insured or claimant. All invoices or requests for payment sent to Broadspire will be returned to sender

IMPORTANT NOTICE

Notice to Alaska Claimants: 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.

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 Arkansas Claimants: 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.

Notice to California Claimants: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a 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 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.

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

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 Florida Claimants: 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.

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

Notice to Indiana Claimants: 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.

Notice to Kentucky Claimants: 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.

Notice to Maine Claimants: 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.

Notice to Maryland Claimants: 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 is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Minnesota Claimants: A person who submits an application or files a claim with intent to defraud or helps commits a fraud against an insurer is guilty of a crime.

Notice to New Hampshire Claimants: 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.

Notice to New Jersey Claimants: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Notice to New Mexico Claimants: 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.

Notice to New York 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 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.

Notice to Ohio Claimants: 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 false or deceptive statement is guilty of insurance fraud.

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 Oregon Claimants: Any person who, knowingly and with intent to defraud an insurance company or other person, submits an application or files a claim for insurance that contains any materially false information relating to an insurance company's acceptance of risk, or conceals for the purpose of misleading, information concerning any fact material to an insurance company's acceptance of risk, may be guilty of a fraudulent act, which is a crime.

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 Rhode Island Claimants: 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.

Notice to Virginia Claimants: 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.

Notice to Claimants in all other states: Any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.