

Claim Filing Instructions

Read the instructions for the type of claim you need to file, you may have more than one.

Baggage Delay

Your checked baggage was delayed while you were on your covered trip.

1. Complete all applicable information starting on page 2.
2. Include documentation from your common carrier (airline, cruise line, etc.) confirming the delay and the length of time your luggage was delayed.
3. Include receipts for additional expenses due to the baggage delay.

Baggage & Personal Effects

Your baggage and/or property was lost, stolen, or damaged during your covered trip.

1. Complete all applicable information starting on page 2.
2. Include a police report for theft.
3. Include a copy of the claim you filed with your common carrier (airline, cruise line, etc.) along with their final response for your claim with them. If they paid you a dollar amount, provide proof of that. If they did not pay you anything, please provide proof of that as well.
4. Include proof of ownership for items claimed (purchase receipt, owner's manual, etc.).

Disclaimer: The furnishing of this form, or its receipt by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract. Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

1 Reason for Claim (You may check more than one.)

Baggage Delay
 Lost Baggage
 Stolen Property
 Damaged Baggage or Property
EF PROGRAM NAME:
 EF Educational Tours
 Go Ahead Tours
 Ultimate Break
 College Study Tours
 Gap Year
 Explore America

Primary Insured's Information *Traveler's Information*

2 Name of Primary Insured (The person listed first on your plan.)		3 Date of birth MM/DD/YYYY	
4 Account number		5 Email address	
6 Preferred phone number		7 Fax number	
8 Mailing address (if different than home)		9 City	10 State
			11 Zip Code
12 Home address		13 City	14 State
			15 Zip Code
16 Preferred method of contact: <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> Phone			

Travel Information

17 Customer number	
18 Date of departure MM/DD/YYYY	19 Date of return MM/DD/YYYY

20 Property Values

Item(s)	Estimated Value	Have you received reimbursement?	If so, from whom?	How much?
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
Total	\$			\$

Loss Information

21 Where and how did loss, theft, damage or delay occur?		
22 Date of loss, damage, or delay MM/DD/YYYY		
23a Was the baggage delayed? <input type="checkbox"/> Yes <input type="checkbox"/> No	23b If YES, for how long?	
24a Did loss or damage occur while your property was on or in the custody of common carrier?(I.E. airline, cruise line, railroad, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No	24b If YES, list name of carrier	
25a Did you complete a report at the time of loss or damage? <input type="checkbox"/> Yes <input type="checkbox"/> No	25b If YES, provide a copy of report and list name and title of person to whom notice was given.	
26a Has a claim been filed against your common carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	26b If NO, please do this immediately. If YES have you been paid by the carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	26c If YES, list amount.
27a Is there any other insurance that might cover this loss? (Homeowners, renters, credit card, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No	27b If YES, please list the name of company, policy number, and full address.	

Other Insurance / Authorization

28a Do you have any other travel or out-of-country insurance through employer, spouse's employer, retirement plan or credit card? <input type="checkbox"/> Yes <input type="checkbox"/> No	28b If YES, please indicate name of insurance company
29 Plan number	30 Credit card issuing bank

I AUTHORIZE any insurance company, physician, hospital, and other health care providers, any travel organization or agency, airline carrier, 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 the information obtained by use of the authorization, will be used by Seven Corners to determine eligibility for benefits under this plan. Any information obtained will not be released by Seven Corners to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I further authorize.

I KNOW that I may request to receive a copy of the Authorization. I AGREE that a photographic copy of this authorization is as valid as the original. I AGREE that this Authorization shall be valid for two and one half years from the date shown below. I UNDERSTAND that it is illegal to knowingly file a false or fraudulent claim or to knowingly help someone else file one. I have read and understand the Fraud Notices on page 3 of this document. *A Parent or Legal Guardian may sign on behalf of a minor.*

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.

31 Signature	32 Date MM/DD/YYYY
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Send this form and any accompanying documents to Seven Corners using any of the following methods:

MAIL Seven Corners, Inc. Attn: Claims PO Box 211379 Eagan, MN 55121 (Allow mail 7-10 days for delivery.)	FAX (+01) 317-575-2256	EMAIL tourclaims@sevendcorners.com *Quickest and most preferred*
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Call for help: Local 1-317-582-2658 or Toll-free 1-866-887-7148

Disclaimer: This claim form is used for travel insurance underwritten by United States Fire Insurance Company. C&F and Crum & Forster are registered trademarks of United States Fire Insurance Company. The Crum & Forster group of companies is rated A (Excellent) by AM Best 2023.

HIPAA Authorization to Disclose PHI and Payment Authorization

To prevent any delays in claims handling and payment processing, please sign at the end of both sections of this authorization form.

HIPAA Authorization to Disclose PHI

I authorize Seven Corners, Inc. to disclose protected health information (PHI), which will include the applicable account number and date(s) of the covered benefits received, about _____
_____ (name of covered person) to Fleetcor Technologies, Inc. d/b/a Corpay to fulfill my request for Seven Corners to pay covered travelhealth benefits via Automated Clearing House Network (ACH) transfer. This authorization will expire once all applicable fund transfers have been made. I understand that:

- I can revoke (cancel) this authorization at any time by contacting Seven Corners as follows: Call 800-335-0611 (toll free) or 317-575-2652 (worldwide) or 317-818-2809 (collect). This will not affect any disclosures Seven Corners has made in reliance on this authorization before it receives my cancellation.
- Seven Corners cannot condition payment or eligibility for benefits on whether I sign this authorization. However, if I do not sign it or if I revoke it, Seven Corners may not be able to make payment via ACH transfer.
- Any PHI disclosed under this authorization may be re-disclosed by the recipient and will no longer be protected by the HIPAA Privacy Rule.

Signature: _____

Date: _____

Printed Name: _____

If you are not the covered person, and you are signing this authorization as the covered person's legal representative (parent, guardian, etc.), please describe your legal authority: _____

Payment Authorization

The NAME in the contact information must match exactly the name on the ACH, checking, or wire transfer account. Joint accounts require all names.

Payment Authorization Form

- To prevent any delays in claims handling, please be sure to sign this form.
- The **Name** in contact information must match exactly the name on the ACH, checking, or wire transfer account.
- Joint accounts require all names.

Contact Information

Name Account Holder(s)	Telephone		
Email address	I authorize Seven Corners, Inc. to contact me using this email address to discuss and/or inform me of payment confirmation. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Mailing address (P.O. Boxes are not accepted)	City	State/Province/Region	Postal Code

1 Payment Type

<input type="checkbox"/> Check (check will ship to address above)	<input type="checkbox"/> ACH/EFT: US \$ Canada(CAD) \$ – complete section 2
<input type="checkbox"/> International Wire Transfer – complete section 3	

2 U.S. Account Information

Account type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Full Bank Name:		
Bank street address	City	State/Province/Region	Postal Code
ABA routing number	Account number	SWIFT BIC	

3 International/non-U.S. Account Information - Complete for payment through bank transfer outside the U.S.

Bank's full name			
Bank street address	City	State/Province/Region	Postal Code
Account number	Routing Number (BLZ, BSB, TRNO, branch code, etc.)		
IBAN	SWIFT BIC	Preferred reimbursement currency	

REGULATORY INFORMATION

Bank phone number	Identification number
	Account type: <input type="checkbox"/> ID <input type="checkbox"/> NIT <input type="checkbox"/> RIF <input type="checkbox"/> CPF <input type="checkbox"/> CNPJ <input type="checkbox"/> RUT <input type="checkbox"/> CUIT <input type="checkbox"/> OTHER

I hereby authorize Seven Corners, Inc. (hereinafter COMPANY) to mail any payments to the above listed address and to deposit any amounts owed me for reimbursement of relevant expenses or services rendered by initiating credit entries to my account at the financial institution (hereby BANK) indicated above. Further, I authorize BANK to accept and to credit any credit entries indicated by COMPANY to my account. In the event that COMPANY erroneously deposits funds in my account (by way of example, I am not entitled to the funds or the amount of deposit is incorrect or such funds are deposited in the wrong account), I authorize COMPANY to debit or credit my account in the amount necessary to correct the initial deposit, but in no case shall any debit exceed the amount of the initial deposit. I further agree COMPANY is not responsible for any transaction fees charged and will release Seven Corners of any liability in the event of lost or stolen payments.

Account holder signature	Date
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FRAUD WARNING STATEMENT

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW: 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.

ALASKA: 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.

ARIZONA: 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.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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. 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.

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

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.

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

INDIANA: 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.

KANSAS: A "fraudulent insurance act" means an act committed by 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, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or 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.

KENTUCKY:

Application: 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.

Claim Form: 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.

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 a denial of insurance benefits.

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.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: 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.

NEW JERSEY:

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

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

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.

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.

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.

OKLAHOMA: 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.

OREGON:

IMPORTANT NOTE: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

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 and denial of insurance benefit.

TEXAS: 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.

VIRGINIA: 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.

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.

V.03.22.2024 FRAUD STATEMENT