Trip Interruption

Claim Form & Claimant's Statement

PARTICIPANT'S INFORMATION:

Plan Number:_____

Name(s) of all claimants:

1._____

2._____

3._____

4._____

Email Address: _____ Home Phone #: (_____) _____

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

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

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, added costs or nonrefundable charges incurred by you due to your interruption.

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 INTERRUPTION:

Date Trip was Interrupted: __/___/___ Reason for Interruption:_____

_____

_____

IF INTERRUPTION 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): From____/____/____ To: ____/____/____

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 statements.

Date Completed: _____ Physician's Signature: _____

Taxpayer ID Number: _____

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

In order to process a claim for benefits, I authorize any physician, hospital, or other Medical Provider to release to the Travel Insurance Claims Administrator, or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed two and one-half years from the date signed. I understand I have a right to receive a copy of this authorization.

Date: _____ Signature: _____
(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.

____ Airline Ticket Stub/Receipt
Note: Copies of new airline tickets purchased due to interruption (if applicable) along with documentation of the cost incurred. Please forward the original airline tickets 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: (_____)_____

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.

_____ _____
Signed Date

MAILING INSTRUCTIONS:

Send this form and any accompanying documentation to:

Co-ordinated Benefit Plans, LLC
Attn: Travel Insurance Claims
P.O. Box 26222
Tampa, FL 33623

Or E-mail your information to:
Travelteam@cbpinsure.com