Trip Claim Form

Step 1 – Choose the Type of Claim

☐ **Trip Cancellation**	I am unable to leave on my trip due to an unforeseen event and want to request reimbursement for non-refundable trip payments and deposits.
☐ **Trip Delay**	I had an unforeseen delay that caused me to have additional out-of-pocket expenses such as unplanned hotel accommodations, meals, and local transportation.
☐ **Trip Interruption**	I had an unforeseen interruption that caused me to have unused, non-refundable portions of my trip and/or caused me to purchase new or additional airline, bus, or train tickets.

Step 2 – Provide Documentation (provide all)

Provide the following required documentation:

- ☐ Provide copies or photos of your itinerary and paid invoice.
- ☐ Provide copies or photos of any documentation that supports the reason for your claim.
- ☐ Provide copies or photos of receipts or credit card statements for out-of-pocket expenses.

Step 3 - Submit All Pages of this Claim Form

Completed claim form and documentation can be submitted by either:

- ☐ **Scan/Upload:**
- ☐ **Mail to:**
  Health Special Risk, Inc.
  P.O. Box 250649
  Plano, TX 250649
- ☐ **Email to:** GallagherZurich@hsri.com
- ☐ **Fax to:** 972-512-5818

If you have questions about your claim, our customer service team is available by
phone at 866-409-5734, or by email at GallagherZurich@hsri.com.

About Me

Name of the person completing form (First and Last) **Confirmation/Policy Number**

Mailing address ☐ *Check if this is a change of address.* **City** **State** **Postal code**

Mobile phone **Other phone** **Email address**

Full names of all persons claiming **Relationship to person completing form**

Name of agency/company you purchased your travel insurance from **Date initial deposit paid for trip (mm/dd/yyyy)**

Trip Claim Form

Note – Benefits under any coverage will not be paid for expenses reimbursed or services provided by any other source. Benefits cannot be duplicated under this protection plan and claims will be adjusted in accordance with the terms of the policy.

About What Happened

Please provide a detailed description

Date of Loss *(mm/dd/yyyy)* **Total Amount Requested for Reimbursement** *(USD)*

Breakdown of the Amount Requested for Reimbursement

Description of Expense	**Date** *(mm/dd/yyyy)*	**Amount Requested for Reimbursement** *(USD)*

If you have more expenses, please provide a breakdown on an additional sheet using above format.

Airline Refunds or Credits

Your airline tickets may have value for up to one year from the original scheduled travel date.

Will you be exchanging your airline ticket(s) for future travel? ☐ YES ☐ NO

Refunds or Credits Other than Airline

Will/have you applied for a refund or credit from the travel supplier? ☐ YES ☐ NO

If YES, have you received or do you expect to receive this refund/credit? ☐ YES ☐ NO

If YES, indicate the refund/credit amount in USD: _____

If the claim has been submitted to another insurance company for these expenses, please provide:

Name of Insurance Company **Claim Number**

I DECLARE THE ABOVE INFORMATION IS TRUE, COMPLETE AND CORRECT.

I authorize any other insurance company, under which I have coverage to disclose information as may be necessary with respect of my claim with Zurich American Insurance Company directly. I also authorize Zurich American Insurance Company to disclose to any other insurance company, under which I have coverage, any and all information as may be necessary with respect to my claim.

Signature or typed name of the person completing this form **Date** (mm/dd/yyyy)

☐ The person completing this form understands **checking this agreement box** and **typing your name** in the signature box above constitutes an electronic signature and consent to file this claim electronically. Electronic signatures are legal and enforceable in the same fashion as a traditional signature.

Claim is Related to a Medical Situation

If claim is not related to a medical situation, do not complete this section.

To be completed by Patient / Guardian

Patient's name (First and Last) **Date of Birth** *(mm/dd/yyyy)*

Insured's name (First and Last) **Insured's relationship to patient**

Policy purchase date *(mm/dd/yyyy)*

To be completed by Physician (This information will be used for the adjudication of travel insurance claims)

1. **Was the patient medically stable for travel on the policy purchase date noted above?** ☐ YES ☐ NO
   (If NO, please provide medical records from the policy purchase date to the present.)
2. **Primary Diagnosis** **Secondary Diagnosis**
3. **When did symptoms first appear or injury occur?** *(mm/dd/yyyy)*
4. **Provide the dates of treatment, primary/secondary diagnosis and treatment provided.**

Primary Diagnosis

Date of Treatment *(mm/dd/yyyy)*	Describe the treatment/condition for this date
a)	a)
b)	b)
c)	c)

Secondary Diagnosis

Date of Treatment *(mm/dd/yyyy)*	Describe the treatment/condition for this date
a)	a)
b)	b)
c)	c)

5. **Provide the name and contact information for physicians involved in the treatment of the patient (including referrals)**

Physician Name (First and Last)	Specialty	Phone Number	Referred To/From *(check one)*	Date of Referral *(mm/dd/yyyy)*
a)			☐ To ☐ From	
b)			☐ To ☐ From	
c)			☐ To ☐ From	

6. **Did you advise the insured to cancel travel plans due to the patient's condition?** ☐ YES ☐ NO **If YES, what date did you advise to cancel?**

Physician Remarks

Physician full address **Fax**

Physician name *(First and Last)* **Taxpayer identification number**

Physician Signature **Date** *(mm/dd/yyyy)*

Claim is Related to a Medical Situation

If claim is not related to a medical situation, do not complete this section.

Patient Consent Form

Patient's full name at time of treatment (First and Last) **Date of Birth** *(mm/dd/yyyy)*

Full address

Purpose of release: **Effective Date of Insurance Coverage:**

ADJUDICATION OF TRAVEL INSURANCE CLAIM

List all physicians consulted for this condition and hospital where confined:

Name *(first and Last)*	**Address**	**Phone**	**Fax**	**Dates** *(mm/dd/yyyy – mm/dd/yyyy)*
				-
				-
				-

You are authorized to give Zurich American Insurance Company and its affiliates, reinsurers, agents, consumer reporting agency, or independent claims administrator acting on behalf of Zurich American Insurance Company, any information concerning insurance coverage, medical care, advice, treatment or supplies, or any other information that may have bearing on the request for benefits submitted in conjunction with the travel-insurance policy.

Information to be released:
All medical records of the Patient for up to 180 days before the Effective Date of Insurance Coverage as shown above through the date of this consent as shown below as applicable based on the patients age as outlined the policy. "Medical records" includes, without limitation, diagnosis list, medication list, physician dictation, office notes, physical therapy records, occupational therapy records, pathology reports, cytology reports and the results of all laboratory tests.

Send to:
Health Special Risk, Inc.
P.O. Box 250649
Plano, TX 75025-0649
Telephone: 866-409-5734 Fax: 972-512-5818

By signing below, I understand that:

1. The information in my health record may include information relating to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I have the right to revoke this consent at any time by providing my written revocation to the facility where my records are kept.
3. A revocation will not apply to information that has already been released in response to this consent.
4. A revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. Unless otherwise revoked, this consent will expire in six months.
6. Consenting to the disclosure of this health information is voluntary. I can refuse to sign this consent.
7. Any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I authorize Health Special Risk, Inc. to disclose my health or claim information to any relevant source (e.g., airline, tour operator, travel suppliers, etc.) for the purpose of obtaining recoveries or outstanding refunds after my insurance claim has been settled. I hereby assign to Zurich American Insurance Company any benefits or recoveries obtained from these sources for losses covered under this policy. I direct these sources to forward reimbursement to Administrative Concepts, Inc. with regard to these losses.

Signature of patient or authorized person **Date** (mm/dd/yyyy)

Relationship and reason patient is unable to sign

Claim Form Fraud Requirements

Mandatory – Please read and sign below.

All states other than those listed:
For your protection state 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 or benefit with the intent to defraud or deceive any insurer is guilty of a crime and may be subject to criminal and civil penalties and denial of insurance benefits.

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

California
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

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.

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.

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

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.

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.

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.

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.

Puerto Rico
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

I ACKNOWLEDGE that I have read the fraud statement that applies to my state of residence. If my state of residence is not listed, I acknowledge that I have read the "All states other than those listed".

Signature or typed name of the person completing this form **Date** (mm/dd/yyyy)

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