Trip Interruption

Claim Form & Claimant's Statement

CLAIMANT INFORMATION:

Policy Number: _____ User ID_____

Name: _____

Address: _____

City: _____ State: _____ Zip Code:_____ Country: _____

Email Address: _____Phone #:_____

Please advise if you wish to be contacted via email or regular mail_____

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 INTERRUPTION:

Date Trip was interrupted: _____ Reason for interruption: _____

_____

IF INTERRUPTION WAS 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.

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):_____

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:_____

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**_____

CLAIM FORM FRAUD 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.

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.

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 a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fins 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 WARNING :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.

KANSAS: 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 insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

KENTUCKY: 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

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.

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

NEW MEXICO and 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.

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.

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 benefits.

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: 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 may have violated state law.

MAILING INSTRUCTIONS:

Send this form and any accompanying documentation to:
Attention: Co-ordinated Benefit Plans, LLC On Behalf of Crum and Forster Insurance Company
PO Box 2069
Fairhope AL, 36533
OR
Email to: TrawickClaims@cbpinsure.com
Fax: 866-616-0444 or 251-666-1806
Customer Care: 866-696-0409 251-928-0939
Check claim status online at (Registration is required): https://mytrawick.com/Accounts/Member/Login