iTravelInsured Trip Cancellation/ Trip Interruption Claim Form

Please print legibly and complete ALL SECTIONS (front and back) of this application. Send this form by secure methods only.
Address: International Medical Group, Travel Claims, PO Box 241853, Apple Valley, MN 55124
Call: 1.866.243.7524 or 1.317.655.9798; **Fax:** +1.317.927.6882
Email: iTravelClaims@imglobal.com
www.imglobal.com

To report a loss, return the required documentation, along with your original, signed claim form to IMG® Claims. A delay in the processing of the claim will occur if unacceptable proof of loss or an incomplete claim form is submitted. Proof of claim must be submitted within 90 days of the date of loss. IMG reserves the right to obtain further information needed to determine eligibility for benefits and the proper payee.

The following documentation will initially be required to begin processing of your claim.

- ☐ The fully completed claim form, signed, and dated
- ☐ The complete trip itinerary & a copy of itemized invoice showing amount paid for trip
  Examples: E-ticket or paper ticket, hotel charges, service fees, and other accommodation expenses
- ☐ Proof of payment for the trip
  Examples: credit card statement, cancelled check, common carrier, and travel supplier receipts
- ☐ Statement from common carrier and travel supplier indicating if any refund, reimbursement, credit, and/or voucher was issued. If no refund, reimbursement, credit, or voucher was issued, a copy of the cancellation terms and conditions must be provided to verify you are not entitled to reimbursement or credits from any other source

If trip was cancelled or interrupted due to sickness, injury, or death, include the medical documentation including but not limited to:

- ☐ Attending physician's statement *(completed by a physician)*
- ☐ Copy of death certificate and obituary *(if applicable)*
- ☐ Proof of relationship *(if cancellation is due to the illness, injury, or death of a family member)*

If the trip was cancelled or interrupted due to other causes, include the additional documents to show proof of loss due to any of the "Other Covered Reasons" identified in the insurance contract:

- ☐ Notice of jury duty or copy of summons to appear in court as a witness
- ☐ Letter from employer outlining dates of hire and termination, attesting to permanent transfer of employment, revocation of previously approved time off, verification of your direct involvement in the merger, or attesting to place of employment being rendered unsuitable for business due to a natural disaster, fire, or burglary
- ☐ Documentation from travel supplier outlining the reason and time frame for cessation of services due to weather, strike, mechanical breakdown, or natural disaster
- ☐ Copy of military orders and documentation from commanding officer verifying call to emergency duty due to Natural disaster or revocation of previously granted leave due to war
- ☐ A police report documenting the theft of passport or the occurrence of an accident occurring while en route to covered trip, which caused cancellation of the trip
- ☐ Copy of quarantine order from government health authority
- ☐ Letter from transportation authority attesting to hijacking incident
- ☐ Documentation verifying terrorist incident within 30 days of departure date in the city you were scheduled to travel during the trip or proof of mandatory evacuation by local government authority at your trip destination due to natural disaster
- ☐ Fire marshal or insurance company report attesting to the fact the primary residence is uninhabitable
- ☐ Proof of hurricane warning issued by National Hurricane Center at the trip destination within 24 hours of your scheduled trip
- ☐ Documentation verifying bankruptcy of travel supplier let to cessation of travel services

PRIMARY CLAIMANT INFORMATION

Insured's Name *(Last, First, Middle)*:	Policy Number:
Mailing Address:	
Email Address:	Cell Phone Number *(With area code)*:

Please note: by providing an email address and cell phone number on this form, you agree to electronic communications (including emails and SMS) about any claims that you have submitted.

PART 1. GENERAL INFORMATION

1. Full Name of Claimant: *(List all claimants. Attach additional sheets if necessary)*	Date of Birth: ___/___/___ *(MM/ DD/YYYY)*
Policy Number:	Relationship to Insured:
2. Full Name of Claimant:	Date of Birth: ___/___/___ *(MM/ DD/YYYY)*
Policy Number:	Relationship to Insured:
3. Full Name of Claimant:	Date of Birth: ___/___/___ *(MM/ DD/YYYY)*
Policy Number:	Relationship to Insured:
4. Full Name of Claimant:	Date of Birth: ___/___/___ *(MM/ DD/YYYY)*
Policy Number:	Relationship to Insured:

Name of Travel Supplier *(e.g. cruise line, airline, etc.)*:

Travel Agency's Full Name:	Travel Agent's Name:	Telephone Number *(With area code)*:
Travel Agency's Mailing Address:		Email Address:

Initial Deposit Date Paid for Trip:	Scheduled Departure Date:	Schedule Return Date:	Actual Return Date:
___/___/___ *(MM/ DD/YYYY)*	___/___/___ *(MM/ DD/YYYY)*	___/___/___ *(MM/ DD/YYYY)*	___/___/___ *(MM/ DD/YYYY)*

Departure City:	Destination (City, Country, or State):

Please check the box for benefits requested: ☐ Trip Cancellation ☐ Trip Interruption

- If the cancellation and/or interruption is due to sickness, injury, or death, please complete the entire claim form.
- If the cancellation and/or interruption is due to a non-medical reason(s), please complete Parts 2 and 4.

PART 2. EXPLANATION OF LOSS

Describe in detail what occurred:

Date trip cancelled/interrupted:	Total paid for trip prior to cancellation *(do not include travel insurance premium)*:	Total paid per insured prior to cancellation *(US$)*:
___/___/___ *(MM/ DD/YYYY)*		
Total paid for original airfare, per insured (include only if unused airfare is part of the loss claimed):	Did you receive a refund, reimbursement, voucher, or credit from the travel agent, common carrier, or travel supplier? ☐ Yes ☐ No	If yes, please list amount refunded/credited *(US$)*:

Additional losses claimed due to cancellation/interruption:

Type of Expense incurred (hotel, transportation, new tickets):	Date Incurred:	Amount *(US$)*:
1. ______________________	___/___/___ *(MM/ DD/YYYY)*	______________
2. ______________________	___/___/___ *(MM/ DD/YYYY)*	______________
3. ______________________	___/___/___ *(MM/ DD/YYYY)*	______________
Please use a separate sheet of paper for any additional expenses. Proof of payment is required for all losses claimed. Claims cannot be processed without proof of loss.		
	Total Amount of Cancellation/Interruption Losses:	

PART 3. MEDICAL INFORMATION - Complete for cancellation/interruption due to sickness, injury, or death		
Patient's Name:	Relationship to Insured:	Date Symptoms First Noticed: ___/___/___ *(MM/DD/YYYY)*
Nature of Illness:		Date of First Consultation: ___/___/___ *(MM/DD/YYYY)*
Describe onset, diagnosis, and treatment:		
For injury, describe injury:		Date of First Consultation: ___/___/___ *(MM/DD/YYYY)*
How and where did the accident occur:		
If hospitalized, hospital name, website, and address:		Dates of Confinement: ___/___/___ *(MM/DD/YYYY)* From: To:
Name and address of treating physician:		Telephone Number *(with area code)*: Fax Number *(with area code)*:

PART 4. OTHER COVERAGE	
Do you have any other insurance or coverage related to the loss *(e.g. Domestic Health Insurance, Travel, Homeowners, etc.)*?	☐ Yes ☐ No
Do you have any other travel insurance coverage?	☐ Yes ☐ No
Did you report the loss to any other insurance company?	☐ Yes ☐ No

If Yes, which company:			
Name of Company:	Policy/Certificate Number:	Telephone Number *(With area code)*:	Website:
1. ___ Address: ___	___	___	___
2. ___ Address: ___	___	___	___
3. ___ Address: ___	___	___	___
(Please attach a separate sheet if necessary)			

PART 5. CERTIFICATE OF MEDICAL CONDITION/MEDICAL PROVIDER'S STATEMENT

Patient's Name:	Date of Birth: ___/___/___ *(MM/ DD/YYYY)*
Insured's Name:	Patient's Relationship to Insured:
Policy Number:	Policy Purchase Date: ___/___/___ *(MM/ DD/YYYY)*

ATTENDING PHYSICIAN'S STATEMENT—MUST BE COMPLETED AND SIGNED BY THE PHYSICIAN

1. Diagnosis: Nature of sickness/injury causing cancellation/interruption *(Please be specific)*:
   a. Primary diagnosis of ICD-9 code: ______________________________
   b. Secondary diagnosis of ICD-9 code: ______________________________

2. When did symptoms of sickness or injury first occur? ___/___/___ *(MM/ DD/YYYY)*

3. When did the patient first consult you for this condition? ___/___/___ *(MM/ DD/YYYY)*

4. If patient was referred from another provider, name of provider, address and telephone number *(With area code)*:

5. Name, address, and telephone number of other medical personnel involved:

6. Was there any medical condition, injury, illness, or sickness that would interfere with the insured's trip? ☐ Yes ☐ No

   If yes, please explain and indicate when patient was determined not to be medically fit to travel: ______________________

7. List all dates of treatment and services for this condition

Date of Services: ___/___/___ *(MM/ DD/YYYY)*	Describe the Condition/Treatment:
(Please attach a separate sheet if necessary)	

8. Has the patient been hospitalized for this condition or related condition(s)? ☐ Yes ☐ No

   If yes, date of first admission ___/___/___ *(MM/ DD/YYYY)* Date of discharge: ___/___/___ *(MM/ DD/YYYY)*

9. On what date did this condition first prevent or restrict the patient from traveling? ___/___/___ *(MM/ DD/YYYY)*

10. On what date would the patient not be restricted and medically fit to travel?

11. Did you advise the insured to cancel travel plans prior to departure or return home early a result of the sickness or injury?

    ☐ Yes ☐ No If yes, on what date? ___/___/___ *(MM/ DD/YYYY)* Please explain:

    If No, on what date was the insured prevented from participating in the trip? ___/___/___ *(MM/ DD/YYYY)*

12. If condition was related to pregnancy, date of conception: ___/___/___ *(MM/ DD/YYYY)* Expected Delivery Date: ___/___/___ *(MM/ DD/YYYY)*

13. Was this sickness/injury the sole cause of the patient's medically imposed restrictions? ☐ Yes ☐ No

    If no, please explain:

Additional physician comments:

Signature of Physician:	Date Completed: ___/___/___ *(MM/ DD/YYYY)*
Name of Physician:	Telephone Number *(With area code)*:
Address of Physician:	
Taxpayer ID Number:	Fax Number *(With area code)*:

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 and 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, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and 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 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: 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.

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.

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.

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 and 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.

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.

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.

AUTHORIZATION

The undersigned authorizes any health plan, healthcare provider, healthcare professional, MIB, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency, employer, benefit plan, or any other organization or person that has provided care, advice, diagnosis, payment, treatment, or services to the insured or on the insured's behalf, has any records or knowledge of the insured's health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the insured, and any non-medical information about the insured, to disclose the insured's entire medical record, file, history, medications, and any other information concerning the insured and to give any and all such information to the insured's agent of record and authorized representatives of the insurer, IMG, and their affiliates, and subsidiaries.

This information will be used to evaluate claims for benefits. Individuals have the right to refuse to sign the authorization without negative consequences to treatment or plan enrollment, except IMG will not be able to administer claims, determine benefit eligibility, or issue payments. The authorization is valid for the term of the insurance contract or plan under which a claim has been submitted. The undersigned understands that the insured has the right to receive a copy of this authorization upon request and revoke the authorization at any time in a written communication to IMG. A copy of this shall be as valid as the original. The undersigned acknowledges and understands there is the potential for the information to be subject to redisclosure by the recipient and to no longer be protected by applicable privacy and confidentiality laws.

The undersigned represents and warrants information or documents provided to IMG by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees:

1) Any insurance coverage or benefit is contingent upon any statement made to IMG as being complete and correct
2) Benefits under any contract will be paid only if IMG decides the applicant is entitled to them

Insured Signature: X ______________________	Date: ___/___/___ (MM/DD/YYYY)
Insured Signature: X ______________________	Date: ___/___/___ (MM/DD/YYYY)
Insured Signature: X ______________________	Date: ___/___/___ (MM/DD/YYYY)
Insured Signature: X ______________________	Date: ___/___/___ (MM/DD/YYYY)