Chubb Travel Protection

CHUBB

Leisure Travel Plans for US Residents

Claim Forms

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Chubb Travel Protection Claim Form

Instructions

When reporting the claim please provide your name, Policy ID number, type of claim, and preferred contact information. Once you have completely filled out the appropriate sections of the claim form, submit it to *Administrative Concepts, Inc.* (contact information below). In addition to the claim form, you may be required to provide other specific information. In order to expedite your claim, please provide the applicable documentation based on the coverage(s) you are claiming. A claim form should be completed for each policy issued.

Quick Reference Guide

☐ **Trip Cancellation/Trip Interruption/Trip Delay/Missed Connection** *(complete Part A)*

Paid receipts for all of the following items:

The amount of the non-refundable amounts paid for the trip:

- Any cancellation charges
- Any prepaid, unused, non-refundable airfare and sea or land accommodations
- Any other reasonable additional trip expenses for travel, lodging, or scheduled events that are prepaid, unused, and non-refundable
- The cost of a one-way economy air and/or ground transportation ticket

Proof of covered reason for claim

If applicable, include Attending Physician Statement for the individual with medical condition and complete Part C: Medical Expense

☐ **Baggage & Personal Effects** *(complete Part B)*

Proof of purchase (receipts, credit card statements, etc.)

Police report/incident report

Lost luggage – must file a formal claim with the transportation provider and provide us with copies of all claim forms and proof that the transportation provider has paid its normal reimbursement for lost, stolen, or damaged luggage

☐ **Baggage Delay** *(complete Part B)*

Documentation of delay or misdirection of baggage by common carrier

Proof of purchase (receipts, credit card statements, etc.)

☐ **Medical Expense** *(complete Part C)*

An itemized bill from the treating physician

Prescription – receipt showing claimant's name and the cost of the medication

Attending Physician's Statement

☐ **Repatriation of Remains** *(complete Part C)*

Expense for embalming or cremation

The least costly coffin or receptacle adequate for transporting the remains

Cost to transport the body from place of loss to his/her home country

Escort Services: expense for one (1) family member or companion who is traveling with the covered person to join the covered person's body during the repatriation to the covered person's place of residence

☐ **Car Rental Collision Coverage** *(refer to CRCC Claim Form)*

☐ **Accidental Death & Dismemberment** *(refer to AD&D Claim Form)*

Please email your completed claim form with legible documentation to:

Administrative Concepts, Inc.
PO Box 4000; Collegeville, PA 19426
Email: chubbtravel@acitpa.com

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All Sections need to be completed for claims submissions.

Complete the Part specific to benefit being claimed as listed on page 1.

If you have a covered medical reason, you must complete Part C and include an Attending Physician's Statement.

I. General Information – *please complete or provide a copy of your policy confirmation statement*

Plan Purchased _____ Policy ID Number _____

Travel Company Name _____ Date of Booking _____

Trip Departure Date _____ Trip Return Date _____

Primary Insured Name _____ Primary Insured Date of Birth _____

Parent or Guardian Name if Primary Insured is under 18 _____

Home Phone # _____ Work Phone # _____

Please provide telephone numbers with country and city codes.

Mailing Address _____

Email Address _____

Preferred Contact Method_____

II. Coverage Information – *please complete this section for Medical Expense or Baggage & Personal Effects claims*

Do you have any other insurance that may provide coverage for this claim? (i.e. health or homeowners insurance)

☐ Yes ☐ No

If yes, please provide source of insurance _____

Are claim expenses recoverable from another source? ☐ Yes ☐ No

If yes, please provide details and amounts:

_____

_____

_____

_____

_____

Please email your completed claim form with legible documentation to:

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Email: chubbtravel@acitpa.com

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III. Payment Information *(funds will be issued in U.S. currency)*

Payment to Insured, Guardian or Beneficiary

☐ Mailing address listed on page 2

☐ Direct deposit to your checking account ☐ Direct deposit to your savings account

Name on Account _____

Bank Name _____ Bank Account Number _____

Bank Address _____ Bank Routing # or Swift Code _____

IBAN _____

IV. Claim Information *(complete the Part that applies to your claim)*

Part A. Trip Cancellation/Trip Interruption/Trip Delay/Missed Connection

☐ Trip Cancellation ☐ Trip Interruption ☐ Trip Delay ☐ Missed Connection

Date and time of incident _____ Date Trip Cancelled/Interrupted/Delayed _____

Reason for Claim:

_____

_____

_____

_____

Are all insureds listed on policy impacted? ☐ Yes ☐ No

If no, provide list of insureds impacted.

_____

_____

Was the cancellation/interruption a result of your own injury/sickness? ☐ Yes ☐ No

If yes, please complete Part C.

Was the cancellation/interruption a result of injury/sickness to a relative or person defined in the Policy? ☐ Yes ☐ No

If yes, please complete Part C.

Name _____ Relationship to you _____

Address _____

If claiming Trip Delay, how long was your delay? _____

Please provide all documentation supporting the reason for your Trip Cancellation/Interruption/Delay/Missed Connection.

Please email your completed claim form with legible documentation to:

Administrative Concepts, Inc.
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Email: chubbtravel@acitpa.com

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IV. Claim Information *(continued)*

Part A. Trip Cancellation/Trip Interruption/Trip Delay/Missed Connection *(continued)*

Chart of Claimed Expenses (Please provide receipts supporting the below expenses)

Type of Expense	Name of Individual Associated with Expense	Date of Expense	Receipts Attached	Expense Amount
			Total Sum Claimed	

Part B. Baggage & Personal Effects / Baggage Delay

☐ Baggage & Personal Effects ☐ Baggage Delay

Date of loss / damage / theft _____ Country where loss / damage / theft occurred _____

Details of loss / damage /theft:

_____

_____

_____

To whom was loss / damage / theft reported _____

If articles(s) lost/stolen, what steps were taken regarding recovery of article(s)? *(Provide any written evidence)*

_____

_____

_____

If article(s) damaged, please supply estimates for cost of repairs or a letter from a reputable dealer confirming irreparably damaged. *(Supply receipts: if not available, please supply replacement estimates/invoices.)*

_____

_____

_____

Please email your completed claim form with legible documentation to:

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Email: chubbtravel@acitpa.com

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IV. Claim Information *(continued)*

Part B. Baggage & Personal Effects / Baggage Delay *(continued)*

Is any property lost/damaged/stolen insured by another company? ☐ Yes ☐ No

If yes, please supply name, address, telephone number and policy number.

_____

_____

Please supply name, address, telephone number and policy numbers of homeowners/household contents insurers.

_____

_____

Have you ever had any previous claims on this type of insurance? ☐ Yes ☐ No

If yes, please supply details with relevant dates.

_____

_____

Particulars of Claim

Full Description of Each Item of Property Lost, Damaged, or Stolen	State to Whom Property Belonged	Date of Purchase	Original Purchase Price	Receipts/ Replacement Estimates Attached
			Total Sum Claimed	

Please ensure you provide receipts if possible or replacement estimates from a reputable retailer for items $150.00 or more. Please note, without a receipt provided items claimed over $150.00 will be reduced by 50% from the replacement cost estimate.

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IV. Claim Information *(continued)*

Part C. Medical Expense & Repatriation of Remains

Patient's Name _____ Date of Illness (first symptom) or injury _____

Relationship to Primary Insured _____

Diagnosis or nature of illness or injury:

_____

_____

If injury – please describe:

_____

_____

_____

Date first consulted for this condition _____

Hospital Confinement Date: From _____ To _____

Disability Dates **Total**: From _____ To _____ **Partial**: From _____ To _____

Place of Service _____

Treating Doctor(s) _____

Treating Doctor City, State _____

Primary Care Physician _____

Primary Care Physician City, State _____

Primary Care Physician Phone # _____

Include copy of Attending Physicians Statement with documentation.

Include copy of all itemized medical expenses.

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V. Declaration *(if signing electronically, do not lock document until 3rd signature is complete)*

I declare that the information given is to the best of my knowledge and belief, full, true, and correct:

Signed _____ **Date** _____

Authorization and Assignment of Benefits

I, the undersigned, authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information.

I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I *agree* that a photographic copy of this Authorization shall be as valid as the original.

I understand that I or my authorized representative may request a copy of this authorization.

I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative _____

Relationship *(if other than Insured)*_____ **Date** _____

Mailing Address_____

Patient's Signature and Release (Parent or Guardian, if claim is for a minor), I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine claim payment.

Signature _____**Date** _____

Please email your completed claim form with legible documentation to:

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FRAUD WARNING NOTICES

For all states not specified below: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act, which is a crime.

For residents of Arkansas: 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.

For residents of the District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For residents of 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 IN THE THIRD DEGREE.

For residents of Kansas: 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 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.

For residents of Kentucky: 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.

For residents of Louisiana: 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.

For residents of 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 denial of insurance benefits.

For residents of 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.

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

For residents of 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.

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For residents of 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.**

For residents of 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.

For residents of Oklahoma: WARNING: 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.

For residents of Oregon: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of 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.

For residents of Rhode Island and West Virginia: 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.

For residents of 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 or denial of insurance benefits.

For residents of Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

For residents of 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 FLALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATE STATE LAW.

For residents of 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.

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Chubb Travel Protection Claim Form

Attending Physicians Statement

Section A. Insured Information

Plan Purchased: _____ Policy ID Number: _____

Name: _____ Date of Birth: _____

Parent or Guardian Name (if under 18): _____

Home Address: _____

Home Telephone #: _____ Work Telephone #: _____

Email Address: _____ Preferred Contact Method: _____

Reason for Claim:

_____

_____

_____

_____

Section B. Medical Information *(to be completed by Physician Rendering Treatment)*

Patient's Name: _____

Diagnosis: _____

Date symptoms or injury first occurred: _____

Date first consulted for this condition: _____

Has the patient ever had the same or similar condition? ☐ Yes ☐ No

If yes, please provide the date of the condition: _____

Did you advise the trip to be cancelled due to the patient's medical condition? ☐ Yes ☐ No

If yes, please provide details including date you advised the trip to be cancelled:

_____

_____

_____

Does the patient's condition render them totally or partially disabled? ☐ Yes ☐ No

If yes, disability dates: Total: From _____ To _____ Partial: From _____ To _____

Was the patient able to return to work? ☐ Yes ☐ No

If yes, return to work date: _____

If patient is/was Hospital Confined, Hospital confinement dates: From _____ To _____

Hospital Name: _____

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Section C. Declaration

I declare that the information given is to the best of my knowledge and belief, full, true and correct:

Physician Name_____

Address_____

Physician Signature_____**Dated** _____

I declare that the information given is to the best of my knowledge and belief, full, true and correct:

Signature of Insured or Authorized Representative _____

Relationship (if other than insured) _____**Dated** _____

Address_____

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For residents of Kansas: 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 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.

For residents of Kentucky: 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.

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

For residents of 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.

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For residents of Oklahoma: WARNING: 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.

For residents of Oregon: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of 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.

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For residents of Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

For residents of 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 FLALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATE STATE LAW.

For residents of 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.

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Chubb Travel Protection Claim Form

Car Rental Collision Coverage

Instructions

When reporting the claim please provide your name, Policy ID number, type of claim, and preferred contact information. Once you have completely filled out the appropriate sections of the claim form, submit it to *Administrative Concepts, Inc.* (contact information below). In addition to the claim form, you may be required to provide other specific information. In order to expedite your claim, please provide the applicable documentation based on the coverage(s) you are claiming. A claim form should be completed for each policy issued.

Quick Reference Guide

☐ **Car Rental Collision Coverage**

- Rental Agreement
- Estimate of damages
- Police report/accident report

Please email your completed claim form with legible documentation to:

Administrative Concepts, Inc.
PO Box 4000; Collegeville, PA 19426
Email: chubbtravel@acitpa.com

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All Sections need to be completed for claims submissions.

I. General Information – *please complete or provide a copy of your policy confirmation statement*

Plan Purchased _____ Policy ID Number _____

Travel Company Name _____ Date of Booking _____

Trip Departure Date _____ Trip Return Date _____

Primary Insured Name _____ Primary Insured Date of Birth _____

Parent or Guardian Name if Primary Insured is under 18 _____

Home Phone # _____ Work Phone # _____

Please provide telephone numbers with country and city codes.

Mailing Address _____

Email Address _____

Preferred Contact Method_____

Reason for Claim:

_____

_____

_____

II. Coverage Information

Do you have any other insurance? (i.e. car insurance) ☐ Yes ☐ No

If yes, please provide source of insurance _____

Are claim expenses recoverable from another source? ☐ Yes ☐ No

If yes, please provide details and amounts:

_____

_____

_____

III. Payment Information *(funds will be issued in U.S. currency)*

Payment to Insured, Guardian or Beneficiary

☐ Mailing address listed on page 2

☐ Direct deposit to your checking account ☐ Direct deposit to your savings account

Name on Account _____

Bank Name _____ Bank Account Number _____

Bank Address _____ Bank Routing # or Swift Code _____

IBAN _____

Please email your completed claim form with legible documentation to:

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Email: chubbtravel@acitpa.com

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IV. Car Rental Collision Claim Information *(see list of required documents on page 1)*

Booking/Reservation #: _____ Rental Company: _____

Rental Company Address: _____

Rental Company Phone #: _____ Dates of Rental: _____

Name of person driving rental car: _____ Date of incident: _____

Car Pick Up Date: _____ Car Return Date: _____

Were the Police notified? ☐ Yes ☐ No

Was an accident report made to the rental agency? ☐ Yes ☐ No

Please describe how the loss/accident occurred:

_____

_____

_____

_____

Please describe any damage to the vehicle:

_____

_____

_____

_____

Was Car Rental Collision Coverage Purchased? ☐ Yes ☐ No

Your Auto Insurance Carrier: _____ Auto Policy #: _____

Auto Insurance Carrier Phone #: _____

If accident involved another vehicle, please provide the information below if obtained:

Other Driver 1 Name: _____ Other Driver 1 Auto Insurance: _____

Other Driver 1 Policy #: _____ Other Driver 1 Auto Insurance Phone #: _____

Other Driver 2 Name: _____ Other Driver 2 Auto Insurance: _____

Other Driver 2 Policy #: _____ Other Driver 2 Auto Insurance Phone #: _____

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V. Declaration *(if signing electronically, do not lock document until 3rd signature is complete)*

I declare that the information given is to the best of my knowledge and belief, full, true, and correct:

Signed _____ **Date** _____

Authorization and Assignment of Benefits

I, the undersigned, authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information.

I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I *agree* that a photographic copy of this Authorization shall be as valid as the original.

I understand that I or my authorized representative may request a copy of this authorization.

I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative _____

Relationship *(if other than Insured)*_____ **Date** _____

Mailing Address_____

Patient's Signature and Release (Parent or Guardian, if claim is for a minor), I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine claim payment.

Signature _____ **Date** _____

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For residents of 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 IN THE THIRD DEGREE.

For residents of Kansas: 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 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.

For residents of Kentucky: 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.

For residents of Louisiana: 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.

For residents of 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 denial of insurance benefits.

For residents of 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.

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

For residents of 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.

Please email your completed claim form with legible documentation to:

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Email: chubbtravel@acitpa.com

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For residents of 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.**

For residents of 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.

For residents of Oklahoma: WARNING: 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.

For residents of Oregon: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of 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.

For residents of Rhode Island and West Virginia: 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.

For residents of 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 or denial of insurance benefits.

For residents of Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

For residents of 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 FLALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATE STATE LAW.

For residents of 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.**

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Chubb Travel Protection Claim Form

Accidental Death & Dismemberment / Flight Accident

Instructions

When reporting the claim please provide your name, Policy ID number, type of claim, and preferred contact information. Once you have completely filled out the appropriate sections of the claim form, submit it to *Administrative Concepts, Inc.* (contact information below). In addition to the claim form, you may be required to provide other specific information. In order to expedite your claim, please provide the applicable documentation based on the coverage(s) you are claiming. A claim form should be completed for each policy issued.

Quick Reference Guide

☐ **Accidental Death**

- Certified copy of the final death certificate
- Police report, any autopsy report, any medical records or reports, and any newspaper clippings
- Travel itinerary

☐ **Accidental Dismemberment**

- Policy report, all medical records, any eyewitness statements and complete accident details
- Travel itinerary

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All Sections need to be completed for claims submissions.

I. General Information – *please complete or provide a copy of your policy confirmation statement*

Plan Purchased _____ Policy ID Number _____

Travel Company Name _____ Date of Booking _____

Trip Departure Date _____ Trip Return Date _____

Primary Insured Name _____ Primary Insured Date of Birth _____

Parent or Guardian Name if Primary Insured is under 18 _____

Home Phone # _____ Work Phone # _____

Please provide telephone numbers with country and city codes.

Mailing Address _____

Email Address _____

Preferred Contact Method_____

Reason for Claim:

_____

_____

_____

II. Coverage Information

Do you have any other insurance? ☐ Yes ☐ No

If yes, please provide source of insurance _____

Are claim expenses recoverable from another source? ☐ Yes ☐ No

If yes, please provide details and amounts:

_____

_____

_____

III. Payment Information *(funds will be issued in U.S. currency)*

Payment to Insured, Guardian or Beneficiary

☐ Mailing address listed on page 2

☐ Direct deposit to your checking account ☐ Direct deposit to your savings account

Name on Account _____

Bank Name _____ Bank Account Number _____

Bank Address _____ Bank Routing # or Swift Code _____

IBAN _____

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IV. Accidental Injury or Death Claim Information *(see list of required documents on page 1)*

Name: _____ Date and time of accident: _____

Give details of the accident:

_____

_____

_____

_____

Name and addresses of witnesses to accident:

_____

_____

_____

_____

Diagnosis:

_____

_____

If loss is sight, is loss in both eyes? ☐ Yes ☐ No

If loss is hearing, is loss in both ears? ☐ Yes ☐ No

If loss is speech, is loss total and irreversible? ☐ Yes ☐ No

If loss is extremity, where is severance? _____

Was the loss caused by an accident independent of all other causes? ☐ Yes ☐ No

Was the loss caused in any way by illness? ☐ Yes ☐ No

If yes, list dates you received treatment for this illness: _____

Name and addresses of all physicians consulted

Primary Care Physician: _____

Primary Care Physician City, State: _____

Primary Care Physician Phone #: _____

Name: _____ Date of treatment: _____

Address: _____

Name: _____ Date of treatment: _____

Address: _____

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IV. Accidental Injury or Death Claim Information *(continued)*

What operation was performed? _____

If in a hospital, which one: _____

If in a hospital, dates hospitalized: From _____ To _____

If accident resulted in death, please fill out the below information:

Was there a judicial ruling made on the cause of death by a judge or jury? ☐ Yes ☐ No

If yes, please complete the following and attach a copy of the proceedings and verdict.

Name of person conducting autopsy: _____ Title: _____

Address: _____

First physician attending deceased after injury

Name: _____

Address: _____

Previous medical history

Primary Care Physician: _____

Primary Care Physician City, State: _____

Primary Care Physician Phone #: _____

Was deceased treated for any medical conditions within 5 years prior to accident? ☐ Yes ☐ No

If yes, please list physician(s) in attendance below.

Name: _____

Address: _____

Medical condition: _____

Dates of treatment: _____

Name: _____

Address: _____

Medical condition: _____

Dates of treatment: _____

To be completed if death resulted from motor vehicle accident

Type of Vehicle: _____ Registered Owner: _____

Was the deceased the driver? ☐ Yes ☐ No

Use of vehicle: ☐ Business ☐ Pleasure ☐ Business and Pleasure

Name of law enforcement agency investigating accident: _____

Address: _____

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V. Declaration *(if signing electronically, do not lock document until 3rd signature is complete)*

I declare that the information given is to the best of my knowledge and belief, full, true, and correct:

Signed _____ **Date** _____

Authorization and Assignment of Benefits

I, the undersigned, authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information.

I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I *agree* that a photographic copy of this Authorization shall be as valid as the original.

I understand that I or my authorized representative may request a copy of this authorization.

I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative _____

Relationship *(if other than Insured)*_____ **Date** _____

Mailing Address_____

Patient's Signature and Release (Parent or Guardian, if claim is for a minor), I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine claim payment.

Signature _____**Date** _____

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FRAUD WARNING NOTICES

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For residents of Arkansas: 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.

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