

# Trip Cancellation – Delay – Interruption



## Claim Form & Claimant's Statement

### PRIMARY PLAN PARTICIPANT'S INFORMATION:

ID Number: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Name: \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_  
 Work Phone: (\_\_\_\_) \_\_\_\_/\_\_\_\_/\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Social Security Number: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_

### TRAVEL SUPPLIER / PROVIDER INFORMATION:

Company Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ Contact: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
 Date Travel Arrangements were made: \_\_\_\_/\_\_\_\_/\_\_\_\_ 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, medical bills, hotel receipts, travel itinerary, tour cost, etc.) supporting penalties, added costs or nonrefundable charges incurred by you due to cancellation, delay or disruption.

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 CANCELLATION / DELAY / DISRUPTION:

Cancellation Date/Notice/Delay/Disruption: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place: \_\_\_\_\_ Duration: \_\_\_\_\_ Hours: \_\_\_\_ Min: \_\_\_\_

If Cancellation/Delay/Disruption involves another party: \_\_\_\_\_

Name of party involved: \_\_\_\_\_ Relationship to Primary Plan Participant: \_\_\_\_\_

Reason for Cancellation/Delay/Disruption: \_\_\_\_\_

**IF CANCELLATION / DELAY / DISRUPTION 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 Doctor: \_\_\_\_\_ Address: \_\_\_\_\_

Office Phone #: (\_\_\_\_) \_\_\_\_\_ Office Fax #: (\_\_\_\_) \_\_\_\_\_

Name of patient: \_\_\_\_\_ Age: \_\_\_\_\_

Date symptoms first appeared or accident occurred: \_\_\_\_\_

Date of first treatment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Was patient treated by someone else?: YES NO

If so, by whom?: \_\_\_\_\_ When?: \_\_\_\_\_

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 Seven Corners, 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.

- \_\_\_\_\_ Airline Ticket Stub/Receipt  
**Note:** Only original, paper tickets can be reimbursed. If you received E-tickets, you *must* have them issued at a ticket counter and submit them to be considered for reimbursement. Contact the airline for more information.
- \_\_\_\_\_ Copies of cancelled checks or credit card statements within an invoice from your Travel Provider showing the date of your deposit. If you seek to waive the pre-existing condition exclusion on your claim, you *must* submit proof of insurance purchase within 10 days of making your initial trip deposit.
- \_\_\_\_\_ Police Report
- \_\_\_\_\_ Statement from Hotel/Motel, Airline Carrier or Airport Facility that concerns your Cancellation/Delay.  
**Note:** Any cancellation or delay of flight must be documented by the airline.
- \_\_\_\_\_ Car Rental Agreement
- \_\_\_\_\_ 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: (\_\_\_\_\_) \_\_\_\_\_

I AUTHORIZE any insurance company, physician, hospital, and other health care providers, any travel organization or agency, airline carrier, rental agency, hotel, motel, or similar entity providing lodging on a rental/lease basis or any other person who may have knowledge regarding this claim, to release any information requested regarding this claim and the loss reported.

I UNDERSTAND that Roundtrip Travel Benefits Plan, administered by Seven Corners, does not cover losses caused by injury or sickness to the extent that they are eligible under a primary group insurance, group-type insurance, prepayment, group practice or individual practice coverage and coverage other than school accident-type coverage, now therefore, as a condition for my receipt of immediate benefits under the Seven Corners plan, for claims in connection with injury or sickness beginning on the date shown above, I irrevocably agreed to: (a) assign all benefits payable from my primary insurer to Seven Corners; (b) promptly reimburse Seven Corners if and when I receive payment(s) from my primary insurance; (c) allow Seven Corners to file a claim with my primary insurer to receive direct reimbursement; and (d) when requested by Seven Corners, to furnish Seven Corners with copies of my primary insurer's schedule of benefits.

I UNDERSTAND the information obtained by use of the authorization, will be used by Seven Corners to determine eligibility for benefits under this plan. Any information obtained will not be released by Seven Corners to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I further authorize.

I KNOW that I may request to receive a copy of the Authorization. I AGREE that a photographic copy of this authorization is as valid as the original. I AGREE that this Authorization shall be valid for two and one half years from the date shown below. 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 4 of this document.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

Mailing Instructions:  
Send this form and any accompanying documentation to:

Seven Corners, Inc.  
**Attn: RoundTrip Claims Dept.**  
303 Congressional Boulevard  
Carmel, IN 46032

## State Fraud Notices— For Use On Applications and Claims Forms

**(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.

**(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.

**(Missouri)** An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

**(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.

**(Puerto Rico)** Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

**(Washington)** Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.”

**(All Other States)** 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/or civil penalties.