Baggage and Personal Effects

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:

Name of Tour Operator/Cruise Line/Airline you were traveling with: _____

Scheduled Date of Departure: ____/_____/_____ Scheduled Date of Return: _____/_____/_____

Origination: _____ Destination: _____

Flight Number: _____ Flight Number: _____

Air Carrier: _____ Air Carrier: _____

LOSS INFORMATION:

Date of Loss: _____ /_____ /_____

Please describe what occurred: _____

_____

Place of Loss: (airport, hotel, rental agency, etc.)

Name and Address:_____

Phone #: (_____) _____ Contact: _____

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
- ☐ Baggage Claim Stub/Receipt
- ☐ Police Report
- ☐ Statement from Hotel/Motel, Airline Carrier or Airport Facility that concerns your lost property.
  Note: You must file a report with the appropriate authorities for damaged, lost or stolen property.
- ☐ 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.

☐ Proof of ownership of the items lost or stolen

Note: Acceptable forms of proof of purchase include credit card statements, sales receipts or cancelled checks**.**

☐ Other (please describe):_____

DESCRIPTION OF LOST / STOLEN / DAMAGED ITEMS:

Item(s):	Estimated Value:	Have you received reimbursement?	If so, from whom?	How much?
	$	Yes No		$
	$	Yes No		$
	$	Yes No		$
	$	Yes No		$
	$	Yes No		$
	$	Yes No		$
	$	Yes No		$
	$	Yes No		$
	$	Yes No		$
	$	Yes No		$
	$	Yes No		$
	$	Yes No		$
Total	$			$

(please use another page if you are claiming more items)

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:_____

REIMBURSEMENTAUTHORIZATION AND METHOD

I hereby authorize Co-ordinated Benefit Plans, LLC to mail any payments to the below listed address and to deposit any amounts owed me for reimbursement of medical expenses or services rendered by initiating credit entries to my account at the financial institution (hereby BANK) indicated above. Further, I authorize BANK to accept and to credit any credit entries indicated by Company to my account. In the event that Company erroneously deposits funds in my account (by way of example, I am not entitled to the funds or the amount of deposit Is incorrect or such funds are deposited in the wrong account), I authorize Company to debit or credit my account in the amount necessary to correct the initial deposit, but in no case shall any debit exceed the amount of the initial deposit. I further agree Company is not responsible for any transaction fees charged and will release Co-ordinated Benefit Plans, LLC of any liability in the event of lost or stolen payments. I authorize Co-ordinated Benefit Plans, LLC to contact me using the email address I provided in this form to discuss and/or inform me of payment confirmation.

Account Holder Signature _____ **Date:** _____

Check to Insured's Address, as listed in INSURED INFORMATION section. ◯

Check to other Mailing Address: ◯

Send by Electronic Direct Deposit (fill all fields): ◯

Bank Name:

Name on Account:

Account #/IBAN:

Routing #/ABA # (for Electronic Direct Deposit):

AUTHORIZATION: I hereby authorize Crum & Forster SPC 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 SPC 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