## Trip Delay

**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:**

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 delay.

| 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 | | $ |
| | $ | $ | ◯ Yes ◯ No | | $ |
| Total | $ | $ | | | $ |

**REASON FOR DELAY:**

Date Trip was delayed with Travel Supplier: _____ Date delay ended:_____

_____

**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.

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.

Statement from Hotel/Motel, Airline Carrier or Airport Facility that concerns your Delay.

**Note:** Any cancellation or delay of flight must be documented by the airline.

Car Rental Agreement (if applicable) ☐ Airline Ticket Stub/Receipt (if applicable) ☐ Police Report (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):_____

Please advise if you wish to be contacted via e-mail or regular mail:_____

**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