

Trip Cancellation – Delay – Interruption



Claim Form & Claimant's Statement

PRIMARY PLAN PARTICIPANT'S INFORMATION:

Policy 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 or Facilitator 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: _____

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 the Bordercross Insurance Claims Administrator, For 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)

Physician’s Statement: TO BE COMPLETED BY PHYSICIAN ONLY

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?: _____

If so, by whom?: _____ When?: _____

Diagnosis resulted cancellation/interruption: _____

Are you patient’s usual medical practitioner? _____

Medical history of this or any associated condition: _____

Did you prohibit patient’s traveling by air or otherwise due to this injury/illness (if so date)? _____

Date Completed: _____ Physician’s Signature: _____

Taxpayer ID Number: _____

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: ____/____/____

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
- _____ Copies of cancelled checks or credit card statements within an invoice from your Travel Provider showing the date of your 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.
- _____ Original purchase receipts for additional expenses
- _____ Report from common carrier confirming delay
- _____ 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 the Bordercross Insurance Plan, administered by the Bordercross Insurance Claims Administrator (Claims Administrator), 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 Bordercross Insurance 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 the Claims Administrator; (b) promptly reimburse the Claims Administrator if and when I receive payment(s) from my primary insurance; (c) allow the Claims Administrator to file a claim with my primary insurer to receive direct reimbursement; and (d) when requested by the Claims Administrator, to furnish the Claims Administrator with copies of my primary insurer's schedule of benefits.

I UNDERSTAND the information obtained by use of the authorization, will be used by the Claims Administrator to determine eligibility for benefits under this plan. Any information obtained will not be released by the Claims Administrator 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:

Attn: Bordercross Insurance Claims
303 Congressional Boulevard
Carmel, IN 46032

FRAUD STATEMENTS

General: 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.

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.

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.

Arkansas, Louisiana, Maryland, 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Delaware, Idaho, Indiana: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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.

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 of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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.

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 a denial of insurance benefits.

Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another 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, and subjects the person to criminal and civil penalties.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

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 section 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: 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.

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.

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: 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.

Oregon: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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.

Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes 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 the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.