

# Claim Filing Instructions



## **Trip Cancellation Claim**

*You were unable to depart on your covered trip*

### **What We Need:**

1. Please complete all applicable information listed on the attached claim form.
2. If cancellation was the result of an illness/injury, please have the patient's physician complete the "Physician's Statement" on the attached claim form.
3. Please submit proof of payment for claimed expenses. Acceptable forms of proof of payment are a credit card statement and/or a copy of the front and back of the negotiated check.
4. Copies of the invoice/reservation for hotel, cruise, and tour bookings.
5. Airline e-ticket.
6. Travel supplier cancellation notice. This notice should contain the reservation/itinerary/booking information, date of cancellation, and the penalties.

## **Trip Interruption Claim**

*You started your trip and then had to return home due to an unforeseen event*

### **What We Need:**

1. Please complete all applicable information listed on the attached claim form.
2. If the interruption was the result of an illness/injury, please have the patient's physician complete the "Physician's Statement" on the attached claim form.
3. Please submit proof of payment for claimed expenses. Acceptable forms of proof of payment are a credit card statement and/or a copy of the front and back of the negotiated check.
4. Copies of invoice/reservation for hotel, cruise, and tour bookings.
5. Airline e-ticket (Please include original itinerary and the new itinerary for rescheduled flight).

## **Travel Delay Claim**

*You started your trip and were delayed en route to your final destination*

### **What We Need:**

1. Please complete all applicable information listed on the attached claim form.
2. Provide documentation from the common carrier (airline, cruise line, etc.) confirming the delay, length of the delay, and the reason for delay.
3. Purchase receipts for additional expenses incurred as a result of the delay.
4. Airline itineraries (Please include the original flight itinerary and a copy of the new flight itinerary).

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## **Baggage Delay Claim**

*Your bag did not arrive on time while you were on your covered trip*

### **What We Need:**

1. Please complete all applicable information listed on the attached claim form.
2. Documentation from the common carrier (airline, cruise line, etc.) confirming the delay and the length of time the luggage was delayed.
3. Purchase receipts for additional expenses incurred as a result of the luggage delay.

## **Baggage & Personal Effects Claim**

*Lost or stolen bag and/or property while on your covered trip*

### **What We Need:**

1. Please complete all applicable information listed on the attached claim form.
2. Police report for theft.
3. Copy of the claim filed with the common carrier (airline, cruise line, etc.) along with their final disposition for the filed claim.
4. Proof of ownership for items claimed (purchase receipt, owner's manual, etc.).

## **Medical/Accident Claims**

*You received medical treatment while on a covered trip*

### **What We Need:**

1. Please complete all applicable information listed on the attached claim form.
2. If you have no other insurance, we need the original medical bills that include the date of service, billed amount, type of service, and diagnosis.
3. If you have other insurance, we need the final disposition from the primary insurer listing payment or denial of your claim with them (Explanation of Benefit or "EOB").
4. Proof of payment for medical treatment received (credit card statement or if paid in cash, provider receipt showing charges as paid).

# Accident & Sickness



## Claim Form & Claimant's Statement

### PRIMARY PLAN PARTICIPANT'S INFORMATION:

Certificate 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? \_\_\_\_\_

### OTHER COVERAGE / AUTHORIZATION:

**If no other coverage please forward to our office original medical bills for treatment received while on your covered trip.**

Do you have any other type of coverage? \_\_\_\_\_

If so, please provide the company name and address: \_\_\_\_\_

Type of Policy: \_\_\_\_\_ Policy #: \_\_\_\_\_ Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Have you filed a claim with their office at this time? \_\_\_\_\_ Yes \_\_\_\_\_ No**

**If yes, please note their response:** \_\_\_\_\_

**If not, why not:** \_\_\_\_\_

Total amount you are claiming under this plan: \$ \_\_\_\_\_

### ILLNESS/ACCIDENT STATEMENT – To be Completed by Patient

Name of person having sickness or injury: \_\_\_\_\_

His / Her Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ His / Her Relationship to Primary Plan Participant: \_\_\_\_\_

Date Sickness or Injury Began: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Ended: \_\_\_\_/\_\_\_\_/\_\_\_\_

Nature of Sickness or Injury (If Injury, describe accident, including date and place): \_\_\_\_\_

Period of Hospitalization: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

**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)

**PHYSICIAN'S STATEMENT: – To be Completed by Physician Only**

If treatment received outside United States please send medical report in place of this form.

Name of doctor: \_\_\_\_\_ Address: \_\_\_\_\_

Office phone #:( ) \_\_\_\_\_ 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 above 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: \_\_\_\_\_

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 3 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

## **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.