SEVEN CORNERS

Call for help: 800-335-0477 (toll free)
or 317-575-2656 (worldwide)
or 317-818-2809 (collect)

Claim Form:
Trip Cancel, Trip Delay, or Trip Interrupt

Helpful Tips

- Gather all of the needed supporting documents and send them with this claim to speed up the process of your claim.
- Submit proof of payment for claimed expenses. Acceptable forms of proof of payment include a credit card statement and/or a copy of the front and back of the negotiated check.
- Send this signed form and any accompanying documents to Seven Corners within 90 days from the date of service using any of the methods listed to the right.

Mail
(Allow mail 7-10 days for delivery of a check.)

Seven Corners, Inc.
Attn: Claims
303 Congressional Boulevard
Carmel, IN 46032 USA

Upload
Login to My Account and upload your documents
www.sevencorners.com/login

Fax
317-575-2256

Email
claims@sevencorners.com
(email attachments can not be larger than 10 MB.)

Reason for Claim

1 Select the type of claim you need to fil , you may have more than one:

☐ **Trip Cancellation**
You were unable to depart or your covered trip.

☐ **Trip Interruption**
You started on your trip and then had to return home due to an unforseen event.

☐ **Trip Delay & Missed Connection**
You started your trip and were delayed by a common carrier (airline, cruise line, etc.) en route to, from, or during your scheduled trip.

☐ **Trip Cancellation for Any Reason**
You purchased this option and you canceled your trip for any reason not otherwise covered.

☐ **Single Supplement**
Booked a trip with a companion who canceled, resulting in additional charges for you.

Primary Insured's Information

2 Name of Primary Insured (The person listed first on our plan.)	**3** Date of birth MM/DD/YYYY		
4 Certific te number (You can find this on our I.D. card.)	**5** Email address		
6 Preferred phone number	**7** Fax number		
8 Mailing address (if different than home)	**9** City	**10** State	**11** Zip Code
12 Home address	**13** City	**14** State	**15** Zip Code
16 Preferred method of contact: ☐ Mail ☐ Email ☐ Phone			

Travel Details

17 Scheduled date of departure MM/DD/YYYY	18 Scheduled date of return MM/DD/YYYY
19 Actual date of departure MM/DD/YYYY (trip delay)	20 Actual date of return MM/DD/YYYY (trip interruption/trip delay)

21 Claimed Expenses and Documentation

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. We recommend you keep copies of any documents submitted with this claim.

- 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.
- If you wish to waive the pre-existing condition exclusion on your claim, you must submit proof that you bought this insurance plan within 20 days of your first payment for air/land/sea arrangements.
- Police Report
- Report from common carrier confi ming delay
- Statement from Hotel/Motel, Airline Carrier or Airport Facility that concerns your Cancellation/Delay. Note: Any cancellation or delay of flig t must be documented by the airline.

Category	Amount	Required Supporting Documents for proof of payment
Airfare	$	Airline Ticket Stub/Receipt or E-ticket
Childcare	$	Documents confi ming your payment
Cruise ship	$	Documents confi ming your reservation/payment/partial payment/de
Deposit, non-refundable	$	Copies of canceled checks or credit card statements with an invoice from your Travel Provider showing the date of your deposit
Event Ticket	$	Copy of ticket
Hotel	$	Documents confi ming your reservation/payment/partial payment
Lodging	$	Documents confi ming your reservation/payment/partial payment
Medical Treatment	S	Completed Physician's Statement or medical records, proof of payment
Prescriptions	S	Completed Physician's Statement or medical records, proof of payment
Rental Car	$	Car Rental Agreement
Tour(s)	$	Documents confi ming your reservation/payment/partial payment
Other	$	Original purchase receipts for additional expenses, meals, taxi, etc.
22 Total expenses	$	
23 Refunds	$	Examples: account credits, cash refunds, trip or meal voucher, etc.
24 Total claimed	**$**	

25 If You Are Claiming Airline Tickets, Please Complete The Below Section

Your airline tickets may have value up to one year from the original scheduled departure date. Please indicate below whether you will be exchanging your tickets for another trip. Please note: Your signature on this agreement is not a guarantee of payment. Claim determinations are subject to the terms and conditions of the plan document.

☐ I (We) will not be using our airline ticket(s). Please enclose a copy of all electronic ticket confi mation(s).
☐ I (We) will be exchanging our airline ticket(s) for future travel. Please enclose a copy of all electronic ticket confi mation(s) along with documentation for the cost you incurred for the exchange.

Traveling Companions

26 Companion name	27 Certific te number
28 Companion name	29 Certific te number
30 Companion name	31 Certific te number
32 Companion name	33 Certific te number

34 Reason for Cancellation / Delay / Interruption

If Cancellation / Delay / Interruption Is Due To Medical Reasons

35 Name of person having sickness or injury	36 Date of birth MM/DD/YYYY
37 Relationship to Primary Insured	38 If the person received medical attention please indicate the date of the last treatment MM/DD/YYYY
39 If the person was hospitalized, please enter the Period of Hospitalization MM/DD/YYYY From:	To:

Authorization For Release of Medical Information – To Be Completed by Patient

In order to process a claim for benefit , I authorize any physician, hospital, or other Medical Provider to release to the Seven Corners Insurance Claims Administrator, 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.

40 Date MM/DD/YYYY	41 Signature of Person Suffering Illness or Injury or legally authorized representative

Physician's Statement – To Be Completed by Physician Only

42 Name of doctor	43 Office phone number		44 Office fax number
45 Office mailing address	46 City	47 State	48 Zip code
49 Name of patient	50 Date of birth MM/DD/YYY		
51 Diagnosis that resulted in cancellation/interruption of trip			
52 Date symptoms first appea ed or accident occurred MM/DD/YYYY	53 Treatment Dates MM/DD/YYYY Start:	End:	
54a Was patient treated by anyone else? ☐ Yes ☐ No	54b If **YES**, by whom?		54c If **YES**, when? MM/DD/YYYY
55a Was patient prohibited to travel due to this illness/injury? ☐ Yes ☐ No	55b If **YES**, include dates patient was disabled from travel MM/DD/YYYY From:	To:	
56 Date completed MM/DD/YYYY	57 Physician's signature		

Other Insurance / Authorization

58 If you have any other travel or out-of-country insurance through an employer, spouse's employer, retirement plan or credit card, provide the name:	
59 Plan number	**60** Telephone

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 Travel Benefits lan, 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 p yable 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 y 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 benefit .

I UNDERSTAND the information obtained by use of the authorization, will be used by Seven Corners to determine eligibility for benefits under this plan. ny 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 f audulent claim or to knowingly help someone else file on . I have read and understand the Fraud Notices on page 6 of this document.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an applic tion 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 fi e thousand dollars and the stated value of the claim for each such violation.

61 Signature	**62** Date MM/DD/YYYY

Payment Authorization Form

- To prevent any delays in claims handling, please be sure to sign this form.
- The ***Name*** in contact information must match exactly the name on the ACH, checking, or wire transfer account.
- Joint accounts require all names.

Contact Information

Name *Account Holder(s)*	Telephone		
Email address	I authorize Seven Corners, Inc. to contact me using this email address to discuss and/or inform me of payment confi mation. ☐ **yes** ☐ **no**		
Mailing address (P.O. boxes are not accepted)	City	State/Province/Region	ZIP/Postcode

1 Payment Type

☐ Check (check will ship to address above)
☐ ACH/EFT: US $ Canada(CAD) $ – complete section 2
☐ International Wire Transfer – complete section 3

2 U.S. Account Information

Account type: ☐ Checking ☐ Savings		Full Bank Name:		
Bank street address		City	State	Zip Code/ Postcode
ABA routing number	Account number		SWIFT BIC	

3 International/non-U.S. Account Information - Complete for payment through bank transfer outside the U.S.

Bank's full name			
Bank street address	City	State/Province/Region	Zip Code/ Postcode
Account number	Routing Number (BLZ, BSB, TRNO, branch code, etc.)		
IBAN	SWIFT BIC	Preferred reimbursement currency	

REGULATORY INFORMATION

Bank phone number	Identific tion number
	Account type: ☐ ID ☐ NIT ☐ RIF ☐ CPF ☐ CNPJ ☐ RUT ☐ CUIT ☐ OTHER

I hereby authorize Seven Corners, Inc. (hereinafter COMPANY) to mail any payments to the above 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 (he eby 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 Seven Corners of any liability in the event of lost or stolen payments.

Account holder signature	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 nowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and onfineme t 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 ontaining 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 onfineme t 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, fine , 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 st tement 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 st tement 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 nowingly 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 onfineme t in prison.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a st tement 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 nowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and onfineme t in prison.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a st tement 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 st tement 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 applic tion 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 ontaining 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 insu ance benefit .

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 onfineme t 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 ontaining a false or deceptive statement may have violated state law.

YOU DO NOT NEED TO RETURN THIS PAGE TO US