

Trip Cancel, Trip Delay, or Trip Interrupt Claim Form

Helpful Tips

- Gather all of the needed supporting documents and send them with this claim to speed up the process of your claim. [Here's a guide to help you check that you have the correct supporting documents.](#) »
- 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(s) along with the bank statement reflecting the check payment(s).
- 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.

Upload

Login to your account and upload your documents
sevencorners.com/login

Fax

317-575-2256

Email

claims@sevencorners.com

(email attachments cannot be larger than 25 MB.)

Disclaimer: The furnishing of this form, or its receipt by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract. Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

Reason for Claim

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

- | | |
|---|---|
| <input type="checkbox"/> Trip Cancellation
You were unable to depart on your covered trip. | <input type="checkbox"/> Single Supplement
Booked a trip with a companion who canceled, resulting in additional charges for you. |
| <input type="checkbox"/> Trip Interruption
You started on your trip and then had to return home due to an unforeseen event. | <input type="checkbox"/> Event Ticket Registration Fee Protection
You purchased this option and as a result of a covered reason you were not able to attend the event and so seeking reimbursement for the event ticket registration fees you paid. |
| <input type="checkbox"/> 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. | <input type="checkbox"/> Trip Interruption for Any Reason (IFAR)
You purchased this option and you interrupted your trip for any reason not otherwise covered. |
| <input type="checkbox"/> Trip Cancellation for Any Reason (CFAR)
You purchased this option and you canceled your trip for any reason not otherwise covered. | <input type="checkbox"/> Pet Kennel
Your return home is delayed and you incur additional kennel fees and expenses. |

Primary Insured's Information

2 Name of Primary Insured (The person listed first on your plan.)		3 Date of birth MM/DD/YYYY	
4 Certificate number (You can find this on your I.D. card.)		5 Email address	
6 Preferred phone number		7 Fax number	
8 Mailing address (if different than home)	9 City	10 State/Province/Region	11 Postal Code
12 Home address	13 City	14 State/Province/Region	15 Postal Code
16 Preferred method of contact: <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> Phone			

Travel Information

17 Confirmation number	18 Booking number
19 Date of departure MM/DD/YYYY	20 Date of return MM/DD/YYYY
21 Original destination	22 Travel supplier (if applicable)
23 First day you made any payment for your land/sea/air arrangements. MM/DD/YYYY	

24 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 confirming delay
- Statement from travel supplier (hotel/motel, airline carrier or airport facility) that concerns your Cancellation/Delay. **Note: Any cancellation, delay of flight, refund or credit must be documented by the travel supplier.**

Category	Amount	Required Supporting Documents for Proof of Payment
Airfare	\$	Airline Ticket Stub/Receipt or E-ticket
Childcare	\$	Documents confirming your payment
Cruise ship	\$	Documents confirming your reservation/payment/partial payment/deposit
Deposit, non-refundable	\$	Copies of canceled checks or credit card statements with an invoice from your Travel Supplier showing the date of your deposit
Event Ticket	\$	Copy of ticket
Hotel	\$	Documents confirming your reservation/payment/partial payment
Lodging	\$	Documents confirming your reservation/payment/partial payment
Rental Car	\$	Car Rental Agreement
Tour(s)	\$	Documents confirming your reservation/payment/partial payment
Other	\$	Original purchase receipts for additional expenses, meals, taxi, etc.
25 Total expenses	\$	
26 Refunds	\$	Examples: account credits, cash refunds, trip or meal voucher, etc.
27 Total claimed	\$	

28 Travel Credits/Vouchers

Did you receive credits or vouchers for future travel for any of the above? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, do you plan to use the available credits or vouchers? <input type="checkbox"/> Yes <input type="checkbox"/> No
If you do not wish to use the available credit/voucher for future travel, please provide the following information verifying you wish to be reimbursed this amount:	
Name of Entity Issuing Credit or Voucher	Credit or Voucher Number (If unknown, please list original booking or ticket number)
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Please note that if you plan to use the available credits or vouchers, the amount of the credit/voucher will be deducted from your claim settlement. If you have received credits or vouchers for future travel for more than one travel supplier, please provide this information for each supplier. By stating above you will not be using the credit or vouchers prior to the expiration either yourself or by transfer sale to another party, this credit/voucher shall be considered null and void. If this credit/voucher is used by any party, however, by signing this claim form you agree to reimburse Seven Corners the value of the used credit/voucher if your claim for these is paid by Seven Corners.

29 Travel Companions

Travel Companion Name	Certificate Number	Are you claiming on behalf of this travel companion? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Travel Companion Name	Certificate Number	Are you claiming on behalf of this travel companion? <input type="checkbox"/> Yes <input type="checkbox"/> No

30 Reason for Cancellation / Delay / Interruption

If Cancellation / Delay / Interruption Is Due To Medical Reasons

31 Name of Claimant/Patient (The person suffering illness or injury.)	32 Date of birth MM/DD/YYYY
33 Relationship to Primary Insured <input type="checkbox"/> Same as Primary Insured	34 If the Claimant/Patient received medical attention, please indicate the date of the last treatment MM/DD/YYYY
35 If the Claimant/Patient was hospitalized, please enter the Period of Hospitalization MM/DD/YYYY From: _____ To: _____	

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

In order to process a claim for benefits, 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.	
36 Date MM/DD/YYYY	37 Signature of Person Suffering Illness or Injury or legally authorized representative

Physician's Statement – To Be Completed by Physician Only

38 Name of doctor	39 Office phone number	40 Office fax number	
41 Office mailing address	42 City	43 State/Province/Region	44 Postal Code
45 Name of patient	46 Date of birth MM/DD/YYYY		
47 Diagnosis that resulted in cancellation/interruption of trip			
48 Date symptoms first appeared or accident occurred MM/DD/YYYY	49 Treatment Dates MM/DD/YYYY Start: _____ End: _____		
50a Was patient treated by anyone else? <input type="checkbox"/> Yes <input type="checkbox"/> No	50b If YES, by whom?	50c If YES, when? MM/DD/YYYY	
51a Was patient prohibited to travel due to this illness/injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	51b If YES, include dates patient was disabled from travel MM/DD/YYYY From: _____ To: _____		
52 Date completed MM/DD/YYYY	53 Physician's signature		

Other Insurance

54a Do you have any other travel or out-of-country insurance through employer, spouse's employer, retirement plan or credit card? <input type="checkbox"/> Yes <input type="checkbox"/> No	54b If YES, please indicate name of insurance company		
55 Address	56 City	57 State/Province/Region	58 Postal Code
59 Policy number	60 Phone number		

**IMPORTANT: PLEASE SIGN AND DATE BELOW. RETURN WITH PAGES 1, 2, 3, 4, AND 6 OF THIS FORM.
FAILURE TO DO SO MAY DELAY/HINDER THE PROCESSING OF YOUR CLAIM.**

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 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 7 of this document.

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.

Insured's Signature

Print Name

Date

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 <i>Account Holder(s)</i>	Telephone		
Email address	I authorize Seven Corners, Inc. to contact me using this email address to discuss and/or inform me of payment confirmation. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Mailing address (P.O. Boxes are not accepted)	City	State/Province/Region	Postal Code

1 Payment Type

<input type="checkbox"/> Check (check will ship to address above)	<input type="checkbox"/> ACH/EFT: US \$ Canada(CAD) \$ – complete section 2
<input type="checkbox"/> International Wire Transfer – complete section 3	

2 U.S. Account Information

Account type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Full Bank Name:		
Bank street address	City	State/Province/Region	Postal Code
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	Postal Code
Account number	Routing Number (BLZ, BSB, TRNO, branch code, etc.)		
IBAN	SWIFT BIC	Preferred reimbursement currency	

REGULATORY INFORMATION

Bank phone number	Identification number
	Account type: <input type="checkbox"/> ID <input type="checkbox"/> NIT <input type="checkbox"/> RIF <input type="checkbox"/> CPF <input type="checkbox"/> CNPJ <input type="checkbox"/> RUT <input type="checkbox"/> CUIT <input type="checkbox"/> 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 relevant 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 Seven Corners of any liability in the event of lost or stolen payments.

Account holder signature	Date
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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 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.

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.

YOU DO NOT NEED TO RETURN THIS PAGE TO US