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).

Claim Filing Instructions

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).

Trip Cancellation – Delay – Interruption

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? _____

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	$ 0.00	$ 0.00			$ 0.00

REASON FOR CANCELLATION / DELAY / DISRUPTION:
If you purchased cancel for any reason option and want to file your claim as a cancel for any reason claim please note this under reason for cancellation.

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: _____

_____

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: _____/_____/_____

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 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.

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: _____

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. If you seek to waive the pre-existing condition exclusion on your claim, you *must* submit proof of insurance purchase within 10 days of making your initial trip 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 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 4 of this document.

_____ _____
Signed Date

MAILING INSTRUCTIONS:

Send this form and any accompanying documentation to:

Seven Corners, Inc.
Attn: 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 foe 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.

NATIONWIDE® HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") applies to Nationwide[1] and describes the legal obligations of Nationwide, and your legal rights regarding your protected health information held by Nationwide under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Among other things, this Notice describes how your Protected Health Information ("PHI" as that term is defined below) may be used or disclosed to carry out treatment, payment, or healthcare operations, or for any other purposes that are permitted or required by law.

Nationwide is required by HIPAA and certain state laws to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice so long as it remains in effect. Nationwide reserves the right to change the terms of this Notice and to make the new Notice effective for all PHI maintained by us, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of the revised Notice by mail to your last-known address on file.

Protected Health Information (**PHI)** includes individually identifiable health information that is created or received by Nationwide and that relates to: (1) your past, present, or future physical or mental health or condition, (2) the provision of health care to you, or (3) the past, present, or future payment for the provision of health care to you. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Your Authorization. Certain uses and disclosures of PHI require your authorization. For example, most uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI require a written authorization. Except as outlined below, we will not use or disclose your PHI without your written authorization. If you have given us an authorization, you may revoke it in writing at any time, unless we have already acted on the authorization. Once we receive your written revocation, it will only be effective for future uses and disclosures.

Disclosures for Treatment, Payment or Health Care Operations. We may use or disclose your PHI as permitted by law for your treatment, payment, or health care operations. For instance, for your treatment, a doctor or health facility involved in your care may request information we hold in order to make decisions about your care. For payment, we may disclose your PHI to our pharmacy benefit manager for administration of your prescription drug benefit. For health care operations, we may use and disclose your PHI for our health care operations, which include responding to customer inquiries regarding benefits and claims.

[1] Nationwide Life Insurance Company®, National Casualty Company and the area within Nationwide Mutual Insurance Company® that performs healthcare functions.

Family and Friends Involved In Your Care. With your approval, we may from time to time disclose your PHI to designated family, friends, and others who are involved in your care or in payment for your care in order to facilitate that person's involvement in caring for you or paying for your care.

If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited PHI with such individuals without your approval.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. At times it may be necessary for us to provide your PHI to one or more of these outside persons or organizations. For example, we may disclose your PHI to a business associate to administer claims or to provide support services. In all cases, we require these business associates by contract to appropriately safeguard the privacy of your information.

Other Health-Related Products or Services. We may, from time to time, use your PHI to determine whether you might be interested in or benefit from treatment alternatives or other health-related programs, products, or services which may be available to you as a member of the health plan. For example, we may use your PHI to identify whether you have a particular illness, and advise you that a disease management program to help you manage your illness better is available to you. We will not use your information to communicate with you about products or services which are not health-related without your written permission.

Plan Administration. We may release your PHI to your plan sponsor for administrative purposes, provided we have received certification that the information will be maintained in a confidential manner and not used in any other manner not permitted by law.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your PHI without your authorization. We may release your PHI for any purpose required by law. This may include releasing your PHI to law enforcement agencies; public health agencies; government oversight agencies; workers compensation; for government audits, investigations, or civil or criminal proceedings; for approved research programs; when ordered by a court or administrative agency; to the armed forces if you are a member of the military; and other similar disclosures we are required by law to make.

OTHER PRIVACY LAWS AND REGULATIONS

Certain other state and federal privacy laws and regulations may further restrict access to and uses and disclosures of your personal health information or provide you with additional rights to manage such information. If you have questions regarding these rights, please send a written request to your designated contact as explained in the "Contact Information" section, below.

RIGHTS THAT YOU HAVE

Access to Your PHI. You have the right to copy and/or inspect much of the PHI that we retain on your behalf. All requests for access must be made in writing and signed by you or your personal representative. We may charge you a fee if you request a copy of the information. The amount of the fee will be indicated on the request form. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Amendments to Your PHI. You have the right to request that the PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. If the information is incorrect or incomplete and we decide to make an amendment or correction, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. A request form can be obtained by writing to your designated contact at the address provided in the "Contact Information" section.

Accounting for Disclosures of Your PHI. You have the right to receive an accounting of certain disclosures made by us of your PHI. Requests must be made in writing and signed by you or your personal representative. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Restrictions on Use and Disclosure of Your PHI. You have the right to request restrictions on some of our uses and disclosures of your PHI. We will consider, but are not required to agree to, your restriction request. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Request for Confidential Communications. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your PHI information from us by alternative means or at alternative locations. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Right to be Notified of a Breach. You have the right to be notified in the event we discover a breach of your unsecured PHI.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice, even if you have requested such copy by e-mail or other electronic means.

Complaints. If you believe your privacy rights have been violated, you can file a written complaint with your designated contact as explained in the "Contact Information" section, below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights, in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

CONTACT INFORMATION

If you have any questions about this Notice, need copies of any forms or require further assistance with any of the rights explained above, contact us by calling 1-800-33-0611 or mail your request to:

Seven Corners
Attn: Privacy Information
303 Congressional Blvd.
Carmel, IN 46032

EFFECTIVE DATE

This Notice is effective 9/15/2015

NH-0524-I-09152015