

## Rental Car Collision Claim Form

### Helpful Tips

- If you have no other insurance, submit copies of bills that include the date of service, billed amount, and type of service.
- If you have other insurance, we need the final statement from your other insurance company listing payment or denial of your claim with them (Explanation of Benefits or "EOB").
- Provide proof of your payment for services received (a credit card statement or if you paid cash a receipt from the service provider showing you paid the charges).
- Attach a copy of your car rental agreement.
- Seven Corners processes claims for TravelSafe.
- 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: TravelSafe Claims**  
303 Congressional Boulevard  
Carmel, IN 46032 USA

#### Upload

Login to My Account and upload your documents [www.travelsafe.com/upload](http://www.travelsafe.com/upload)

#### Fax

(+1) 317-575-2256

#### Email

[ts.claims@sevencorners.com](mailto:ts.claims@sevencorners.com)  
(email attachments can not be larger than 10 MB.)

### Primay Insured's Information

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

### Personal Auto Insurance Information

17 Name of Driver's Auto Insurance Company		18 Policy number	19 Phone number	
20 Auto Insurance Company Mailing address		21 City	22 State	23 Zip code
24 Total Claim Amount		25 Auto Insurance Deductible		
26a Did your auto insurance cover any costs? <input type="checkbox"/> Yes <input type="checkbox"/> No		26b If YES, how much? Please attach proof of payment.		

### Rental Company Information

27 Name of rental company		28 Rental car make & model		29 Booking/Reservation number	
30 Email address		31 Fax		32 Phone number	
33 Rental company mailing address		34 City		35 State	36 Zip code

**Details Of Incident / Accident**

37 Date & Time Of Loss / Accident	38 Total Amount Claimed Under This Plan	39 Name of Driver
40 Location of Accident (City, State, Country)		
41a Were the police notified? <input type="checkbox"/> Yes <input type="checkbox"/> No	41b If YES, name of police department	41c If YES, police report number
42 Was an accident report made to rental agency? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please provide a copy.		
43 Briefly describe the incident that resulted in the damage or loss (attach additional page if needed):		

**44 Do you believe a third party was responsible?  Yes  No (If NO, skip this section)**

45 Name of Third Party	46 Third Party Phone Number		
47 Third Party street mailing address	48 City	49 State	50 Zip code
51 Third Party's auto insurance company name	52 Third party's auto insurance phone number	53 Third Party's Auto Policy Number	

**Travel Agent Information**

54 Travel agent	55 Agent name	56 Phone number	
57 Email address	58 Fax		
59 Travel agent mailing address	60 City	61 State	62 Zip code

**Additional Documentation Required** — Include an itemized estimate of the repairs and a copy of the Rental Agreement.

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

- I AUTHORIZE any insurance company, 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.
- 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.

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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	ZIP/Postcode

### 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	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	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 medical 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**