Trip Interruption

Claim Form & Claimant's Statement

Insurance Carrier: Lloyd's of London
Program Reference # EQX2018011
Group Name: UHP Schools - Cigna Wrap Plan

PARTICIPANT'S INFORMATION:

School Name: _____

Name of Participant: _____

Email Address: _____ Home Phone #: (_____) _____

Address: _____ City: _____ State: ____ Zip Code: _____

TRAVEL SUPPLIER / PROVIDER INFORMATION:

If your trip arrangements were made through a Travel Agent – please provide the agent's information, if not – then provide the information as related to the cruise line, land operator or airline as applicable:

Company Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Contact: _____ Phone #: (_____)_____

Scheduled Date of Departure: _____/_____/_____ Scheduled Date of Return: _____/_____/_____

LOSS INFORMATION:

After completing this section, attach copies of all travel documents (original airline tickets, etc.).

Airline:	Original Cost:	Credit, if applicable	Cost of the Rebooked Flight (Credit should be applied and this is the refundable amount)
	$	$	$

REASON INTERRUPTION:

Date Trip was Interrupted: __/___/___ Reason for Interruption:_____

_____

_____

IF INTERRUPTION 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: ____/____/____

To Be Completed by the Attending Physician

Name of patient:_____ Name of Doctor:_____

Address: _____

Office Phone #: (_____)_____ Office Fax #: (_____)_____

Date of Birth: ____/____/____ Date symptoms first appeared or accident occurred: ____/___/___

Date of first treatment: ____/___/____ Was patient treated by someone else?: YES NO

Diagnosis: _____

If so, by whom?: _____ When?: _____

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: _____

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 Travel 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)

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.

____ Copies of cancelled checks or credit card statements that shows all payments made for the trip with an invoice from your Travel Provider showing the total cost paid for the trip.

____ Airline Ticket Stub/Receipt
Note: Copies of new airline tickets purchased due to interruption along with documentation of the cost incurred. Please forward the original airline tickets if applicable.

____ Death Certificate, if due to family member death

____ Please advise if you wish to be contacted via e-mail or regular mail_____

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

CLAIM INSTRUCTIONS:
Send this form and any accompanying documentation to:

Attention: Co-ordinated Benefit Plans, LLC
On Behalf of Underwriter's at Lloyd's, London
P.O. Box 26222
Tampa, FL 33623

Or, E-mail your information to: TravelTeam@cbpinsure.com
Phone: 888-617-1301 / Fax: 800-560-6340

FRAUD STATEMENTS – If you reside in the state of:

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.

District of Columbia: 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.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 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.

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.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Louisiana: 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.

Missouri: An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

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.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."

All Other States: 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/or civil penalties.