



Claim Form

General Information

Contact Information			
Name of insured: _____	Social Security Number _____ -- _____ -- _____		
Home telephone: (____) _____ -- _____	Date of birth: _____		
Work telephone: (____) _____ -- _____	E-mail address: _____		
<i>Home Address</i>		<i>Mailing Address, if different from Home Address</i>	
Street: _____		Street: _____	
City: _____	State: _____	Zip: _____	City: _____ State: _____ Zip: _____
Preferred method of contact: Mail <input type="checkbox"/> E-mail <input type="checkbox"/>		Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/>	

Plan Information	Trip Information
Confirmation/Policy ID #: _____	Departure Date: _____
or Product ID #: _____	Return Date: _____
or Group #: _____	Original destination: _____
or Company ID #: _____	Travel agency name: _____
or Membership #: _____	Date of initial deposit/payment: _____
Reference #: _____	Agent's name: _____
	Agent's phone number: (____) _____ -- _____
	Agent's e-mail address: _____ @ _____

Traveling Companions (please indicate name and relationship to you)	
1. _____	3. _____
2. _____	4. _____

Claim Information	
Reason for filing this claim (short description) _____	Date incident occurred: ____ / ____ / _____
_____	Do you have other insurance that may cover this event?
_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	If Yes, then please provide the name of the insurance company _____

E-mail to: claimsinquiry@allianzassistance.com
 Mail to: Allianz Global Assistance, P.O. BOX 72031, RICHMOND, VA 23255-2031
 Call: 800-334-7525 Fax to: 804-673-1469. We are available 24 hours a day.
 Insurance underwritten by BCS Insurance Company or Jefferson Insurance Company
 Please refer to your policy or letter of confirmation to determine your underwriter
 Plan administered by AGA Service Company



Emergency Medical / Dental

Details of Loss

Please provide a detailed description of the circumstances that caused your claim (attach additional pages if necessary):

Was your medical emergency caused by an accident?

 Yes

 No

Please attach a copy of the accident report to this form.

Do you believe a third party was responsible? Yes No

Name of the third party: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: (____) ____ -- _____

Name(s) of your health insurance provider(s): _____

Coverage may be secondary to your other insurance. A deductible may apply, as outlined in your letter of confirmation.

Claimed Expenses (please attach receipts and reports for all items you are claiming)

<u>Description of Expenses</u>	<u>Where were the Expenses Incurred?</u>	<u>Amount</u>
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
Total expenses:		\$ _____
Subtract credits/reimbursements:		\$ _____
Total claimed amount:		\$ _____

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**PLEASE READ AND SIGN THIS FORM.
FAILURE TO SIGN AND DATE MAY DELAY THE REVIEW OF YOUR CLAIM.**

FRAUD WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, who files a statement of claim containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to criminal prosecution, civil penalties and forfeiture of insurance benefits.

ALASKA FRAUD WARNING: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

CALIFORNIA FRAUD WARNING: 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.

PENNSYLVANIA FRAUD WARNING: 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.

AUTHORIZATION

I authorize any insurance company, travel organization, or any other person or entity to release information regarding this claim. I understand that this information will be used by AGA Service Company, claim administrator, or its authorized representatives for the purpose of evaluating and determining coverage for this claim.

By signing this claim form, I certify that all information given above is true and complete to the best of my knowledge.

By signing this form, I/we assign to the insurer all of my/our rights, title and interest in and to any sums owed to me/us by any entity, including any applicable bonds that may apply, for which I/we receive compensation from the insurer based on this claim. I/we agree to cooperate with the insurer and AGA Service Company, including providing or executing any necessary documentation, to assist the insurer and AGA Service Company in their efforts to collect any such sums.

Signature: _____

Date Signed: ____/____/____

Print Name: _____

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