



# Claim Form

## General Information

<b>Contact Information</b>			
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: _____	City: _____	State: _____
	Zip: _____		Zip: _____
Preferred method of contact:      Mail <input type="checkbox"/> E-mail <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/>			

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

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

<b>Claim Information</b>	
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](mailto: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



## Trip Cancellation / Trip Interruption / Travel Delay / Missed Connection

### Details of Loss

Please describe in detail all circumstances that caused your cancellation, interruption, or delay (attach additional pages if needed):

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Did you contact your travel agent or travel supplier when you cancelled or interrupted this trip?

Yes Date \_\_\_\_\_
  No

Was the reason for the trip cancellation, interruption, or delay of a **medical** or **non-medical** nature?

Medical
  Non-Medical

- Please complete this entire form.
- Attach the enclosed Physician Statement Form completed by an appropriate physician.
- If your cancellation, interruption, or delay was due to someone's death, please attach a copy of the death certificate.

Please skip to the **Claimed Expenses** section below.

### Details of Medical Condition

Name of patient: \_\_\_\_\_ Relationship to named insured: \_\_\_\_\_

Nature of medical condition: \_\_\_\_\_ Date condition first began: \_\_\_\_\_

\_\_\_\_\_ Date of first treatment: \_\_\_\_\_

Were you treated for this condition prior to the purchase of this insurance?  Yes  No

If this is an accident resulting in injury, was an accident report completed?  Yes  No

(Please enclose a copy)

Please list doctors consulted for this condition.

	Name	Address	Phone	Last seen on
1.	_____	_____	( ) ___ - _____	___/___/___
2.	_____	_____	( ) ___ - _____	___/___/___
3.	_____	_____	( ) ___ - _____	___/___/___

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**Claimed Expenses**

<u>Category</u>	<u>Amount</u>	<u>Required Supporting Documentation*</u>
Airfare	\$ _____	E-ticket receipt <b>or</b> original paper airline tickets
Lodging	\$ _____	Documents confirming your reservation/payment/partial payment
Tour(s)	\$ _____	Copy of the invoice
<i>Other (list below)</i>		
_____	\$ _____	Please provide sufficient supporting documentation, such as credit card statements, copies of cancelled checks, receipts, etc.
_____	\$ _____	
_____	\$ _____	
<b>Total Expenses</b>	\$ _____	
Less refunds	\$ _____	<i>Examples: account credits, cash refunds, trip or meal vouchers, etc.</i>
<b>Total Claimed</b>	\$ _____	

\* We reserve the right to request additional information/documentation as needed to process the claim.

**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 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, a company of Allianz Global Assistance, claim administrator, or its authorized representatives for the purpose of evaluating and determining coverage for this claim.

**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 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.**

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

Signature: \_\_\_\_\_

Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name: \_\_\_\_\_

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Global Assistance



## Physician Statement Form

### To be completed by Primary Insured

Primary Insured's Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Insurance Purchase Date: \_\_\_\_\_

### To be completed by Examining Physician

#### Patient Information

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_

#### Physician Information

Examining Physician's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_

Are you the patient's primary care physician?

Yes

No

Who is this patient's primary care physician?

Name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_

Was the patient referred to you by the primary care physician?

Yes

No

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**Patient's Diagnosis:**

Did you perform an actual examination?

Yes

No

Date of the exam: \_\_\_ / \_\_\_ / \_\_\_\_\_

Please indicate the primary diagnosis for which you examined the patient:

ICD-9 Code: \_\_\_\_\_

Date symptoms first appeared or accident occurred: \_\_\_ / \_\_\_ / \_\_\_\_\_

Is this condition a complication of an underlying condition?

Yes (specify below)

No

Please list the dates of the patient's office visits in the 120 days before the insurance purchase date, noted above. **Circle the dates where you treated the patient for the above stated condition.**

___ / ___ / _____	___ / ___ / _____	___ / ___ / _____	___ / ___ / _____
___ / ___ / _____	___ / ___ / _____	___ / ___ / _____	___ / ___ / _____

Did you advise the trip be cancelled or interrupted due to the patient's medical condition?

Yes Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

No

Please explain why you made this recommendation. Provide details on the circumstances and medical diagnosis of the patient that you consider relevant to the insured's decision to cancel or interrupt their trip due to injury or illness.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please explain why you did not make this recommendation. Provide details on the circumstances and medical diagnosis of the patient that you consider relevant to the insured's decision to cancel or interrupt their trip due to injury or illness.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If the patient is the insured, on what date did he/she become medically unable to travel? \_\_\_ / \_\_\_ / \_\_\_\_\_

By my signature and stamp below, I hereby certify that the above is true and correct

Physician Signature: \_\_\_\_\_ Date \_\_\_ / \_\_\_ / \_\_\_\_\_

Physician Stamp:

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