

Claim Form: Trip Cancel, Trip Delay, or Trip Interrupt

Helpful Tips

- Gather all of the needed supporting documents and send them with this claim to speed up the process of your claim.
- Submit proof of payment for claimed expenses. Acceptable forms of proof of payment include a credit card statement and/or a copy of the front and back of the negotiated check.
- 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

Fax

(+1) 317-575-2256

Email

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

Reason for Claim

1 Select the type of claim you need to file; you may have more than one. Read your Plan Document carefully to determine which coverage or coverages apply:

- Trip Cancellation
- Trip Interruption
- Trip Delay & Missed Connection
- Trip Cancellation for Any Reason
- Single Supplement

Primary Insured's Information

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

Travel Details

17 Scheduled date of departure MM/DD/YYYY	18 Scheduled date of return MM/DD/YYYY
19 Actual date of departure MM/DD/YYYY (trip delay)	20 Actual date of return MM/DD/YYYY (trip interruption/trip delay)

21 Claimed Expenses and Documentation

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. We recommend you keep copies of any documents submitted with this claim.

- 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.
- If you wish to waive the pre-existing condition exclusion on your claim, you must submit proof that you bought this insurance plan within 21 days of your first payment for air/land/sea arrangements.
- Police Report
- Report from common carrier confirming delay
- 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.

Category	Amount	Required Supporting Documents for proof of payment
Airfare	\$	Airline Ticket Stub/Receipt or E-ticket
Childcare	\$	Documents confirming your payment
Cruise Ship	\$	Documents confirming your reservation/payment/partial payment/deposit
Deposit, non-refundable	\$	Copies of canceled checks or credit card statements with an invoice from your Travel Provider showing the date of your deposit
Event Ticket	\$	Copy of ticket
Hotel	\$	Documents confirming your reservation/payment/partial payment
Lodging	\$	Documents confirming your reservation/payment/partial payment
Medical Treatment	\$	Completed Physician's Statement or medical records, proof of payment
Prescriptions	\$	Completed Physician's Statement or medical records, proof of payment
Rental Car	\$	Car Rental Agreement
Tour(s)	\$	Documents confirming your reservation/payment/partial payment
Other	\$	Original purchase receipts for additional expenses, meals, taxi, etc.
22 Total expenses	\$	
23 Refunds	\$	Examples: account credits, cash refunds, trip or meal voucher, etc.
24 Total claimed	\$	

25 If You Are Claiming Airline Tickets, Please Complete The Below Section

Your airline tickets may have value up to one year from the original scheduled departure date. Please indicate below whether you will be exchanging your tickets for another trip. Please note: Your signature on this agreement is not a guarantee of payment. Claim determinations are subject to the terms and conditions of the plan document.

- I (We) will not be using our airline ticket(s). Please enclose a copy of all electronic ticket confirmation(s).
- I (We) will be exchanging our airline ticket(s) for future travel. Please enclose a copy of all electronic ticket confirmation(s) along with documentation for the cost you incurred for the exchange.

Traveling Companions

26 Companion name	27 Certificate number
28 Companion name	29 Certificate number
30 Companion name	31 Certificate number
32 Companion name	33 Certificate number

34 Reason for Cancellation / Delay / Interruption

If Cancellation / Delay / Interruption Is Due To Medical Reasons

35 Name of person having sickness or injury	36 Date of birth MM/DD/YYYY
37 Relationship to Primary Insured	38 If the person received medical attention please indicate the date of the last treatment MM/DD/YYYY
39 If the person was hospitalized, please enter the Period of Hospitalization MM/DD/YYYY 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 Seven Corners 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.	
40 Date MM/DD/YYYY	41 Signature of Person Suffering Illness or Injury or legally authorized representative

Physician’s Statement – To Be Completed by Physician Only

42 Name of doctor	43 Office phone number	44 Office fax number	
45 Office mailing address	46 City	47 State	48 Zip code
49 Name of patient	50 Date of birth MM/DD/YYYY		
51 Diagnosis that resulted in cancellation/interruption of trip			
52 Date symptoms first appeared or accident occurred MM/DD/YYYY	53 Treatment Dates Start Date MM/DD/YYYY to End Date MM/DD/YYYY		
54a Was patient treated by anyone else? <input type="checkbox"/> Yes <input type="checkbox"/> No	54b If YES, by whom?	54c If YES, when? MM/DD/YYYY	
55 Was patient prohibited to travel due to this illness/injury? <input type="checkbox"/> Yes <input type="checkbox"/> No			
56 Date completed MM/DD/YYYY	57 Physician's signature		

Other Insurance / Authorization

58 If you have any other travel or out-of-country insurance through an employer, spouse's employer, retirement plan or credit card, provide the name:	
59 Plan number	60 Telephone

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 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 re-insuring 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 6 of this document.

61 Signature	62 Date MM/DD/YYYY
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Payment Authorization Form

The **Name** in box 2 must match exactly the name on the ACH, checking, or wire transfer account. Joint accounts require all names.

1 Payment Type

Method of payment:	
<input type="checkbox"/> International Wire Transfer – complete sections 2 and 4	<input type="checkbox"/> ACH: U.S. \$ – complete sections 2 and 3
<input type="checkbox"/> Check (check will ship to address in section 2) – complete sections 2 and 3	<input type="checkbox"/> ACH: Canada \$, Euros & Pounds – complete sections 2 and 4

2 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 Code/Postcode

3 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	

4 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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Fraud Warnings & Disclosures

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 for 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.

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