

**Claims Administration Office for Transamerica Casualty Insurance**

**Travelers Claims**

4600 Witmer Industrial Estates, Suite 6

Niagara Falls, NY 14305

Telephone: 1-866-968-2061 Fax: 877-367-2496

**TRIP CANCELLATION OR  
TRIP INTERRUPTION  
MEDICAL CLAIM FORM**

**Please Note:** *Benefits under any coverage will not be paid for expenses reimbursed or services provided by any other source. Benefits cannot be duplicated under this Protection Plan.*

**PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF THE OCCURRENCE**

<b>Part I GENERAL INFORMATION</b>				
Claimant's Name <i>(Last, First)</i>		Conf. No.	Date of Birth	
Full Address				
Home Phone No.		Business Phone No.		
Full name of all persons claiming		Ages	Relationship to patient <i>(if applicable)</i>	Policy No./Confirmation No.
1) _____		_____	_____	_____
2) _____		_____	_____	_____
3) _____		_____	_____	_____
4) _____		_____	_____	_____
Name or Tour Operator (e.g. Cruise Line, Airline, etc)				
Travel Agency's Name		Travel Agent's Name	Telephone No.	
Travel Agency's Full Address				
Date Initial Deposit Paid for Trip <i>(MM / DD / YY)</i>	Date of Final Payment for Trip <i>(MM / DD / YY)</i>	Departure Date <i>(MM / DD / YY)</i>	Scheduled Return Date <i>(MM / DD / YY)</i>	Actual Return Date <i>(MM / DD / YY)</i>
Departure City		Destination <i>(City, Country)</i>		

<b>Part II EXPLANATION OF LOSS</b>			
Reason for cancellation/interruption			
Date trip was cancelled/interrupted <i>(MM / DD / YY)</i>	Total Amount of Claim (in US \$)	Tour Cost Per Person (in US \$)	Cruise Cost Per Person (in US \$)
Air Fare Per Person (in US \$)	Did you receive a refund from the Travel Agent/Tour Operator after cancellation? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please Indicate the Amount (in US \$)	
For Trip Interruption, please indicate any additional transportation cost incurred			
Type of Expense	Date incurred <i>(MM / DD / YY)</i>	Amount	
1) _____	_____	_____	
2) _____	_____	_____	
3) _____	_____	_____	
Please enclose the original receipts for the above claimed expenses			

**IMPORTANT – CLAIM CANNOT BE PROCESSED IF THIS FORM IS INCOMPLETE. PLEASE COMPLETE ALL APPLICABLE AREAS.**

Part III MEDICAL INFORMATION		
Patient's Name	Nature of injury or sickness	Date symptoms first noticed ( MM / DD / YY )
For Injury, when, how and where did the accident occur?		Date of first consultation ( MM / DD / YY )
For Sickness, describe onset, diagnosis and treatment		Date of first consultation ( MM / DD / YY )
If hospitalized please indicate the name and address of Hospital	Date of confinement From: ( MM / DD / YY )	To: ( MM / DD / YY )
Name of Family Physician	Telephone No.	Fax No.

Part IV OTHER COVERAGE		
Did you purchase any portion of your trip on a Credit Card? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, name and type of Credit Card (e.g. Visa Gold card)	
Do you have any other Insurance Coverage/Plans? (e.g. Travel, Credit Cards, etc) <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your loss been reported to any other Insurance Company? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, which Company?
1) Name of Insurance Company	Policy No.	Telephone No.
Address of Insurance Company		
2) Name of Insurance Company	Policy No.	Telephone No.
Address of Insurance Company		
3) Name of Insurance Company	Policy No.	Telephone No.
Address of Insurance Company		

<b>I DECLARE THAT THE ABOVE INFORMATION IS TRUE, COMPLETE AND CORRECT.</b>	
<i>I/We authorize any other insurance plan, under which I/We have coverage, to disclose information as may be necessary or to make payment in respect of my/our claim to Transamerica Casualty Insurance Company directly. I/We also authorize Transamerica Casualty Insurance Company to disclose to any other Plan, under which I/We have coverage, any and all information as may be necessary with respect to my/our claim.</i>	
_____ Signature of Insured/Claimant	_____ Date ( MM / DD / YY )
_____ Signature of Insured/Claimant	_____ Date ( MM / DD / YY )

**Part V TO BE COMPLETED BY INSURED**

Patient's Name \_\_\_\_\_ Patient's Date of Birth (MM/DD/YY) \_\_\_\_ | \_\_\_\_ | \_\_\_\_  
Insured's Name \_\_\_\_\_ Insured's relationship to Patient \_\_\_\_\_  
Conf. No. \_\_\_\_\_ Policy purchase date (MM/DD/YY) \_\_\_\_ | \_\_\_\_ | \_\_\_\_  
Scheduled departure date (MM/DD/YY) \_\_\_\_ | \_\_\_\_ | \_\_\_\_ Scheduled return date (MM/DD/YY) \_\_\_\_ | \_\_\_\_ | \_\_\_\_

**Part VI ATTENDING PHYSICIAN'S STATEMENT - TO BE COMPLETED BY THE PHYSICIAN**

1. Diagnosis - Nature of Injury or Sickness causing Cancellation/Interruption (Please Be Specific)  
a) Primary Diagnosis \_\_\_\_\_  
b) Secondary Diagnosis \_\_\_\_\_

2. a) When did symptoms first appear or injury occur? (MM/DD/YY) \_\_\_\_ | \_\_\_\_ | \_\_\_\_  
b) When did Patient first consult you? (MM/DD/YY) \_\_\_\_ | \_\_\_\_ | \_\_\_\_  
c) If Patient was referred **from** another physician, name of other physician. \_\_\_\_\_ Tel No. ( \_\_\_\_ ) \_\_\_\_\_  
d) If Patient was referred **to** another physician, name of other physician. \_\_\_\_\_ Tel No. ( \_\_\_\_ ) \_\_\_\_\_  
e) Names & Contact Numbers of all other physicians involved. \_\_\_\_\_

3. As of the purchase date of the policy (noted in Part V) was the insured disabled from travel?  
 Yes  No

4. Dates of all medical visits as it relates to the condition causing Cancellation/Interruption:  

Date of Consultation (MM/DD/YY)	Describe the Condition/Treatment	Medication Prescribed/Changed
a) ____   ____   ____	_____	_____
b) ____   ____   ____	_____	_____
c) ____   ____   ____	_____	_____

5. Has the Patient been hospitalized for this condition or related condition(s) in the past 12 months?  Yes  No  
If Yes, date of admittance: (MM/DD/YY) \_\_\_\_ | \_\_\_\_ | \_\_\_\_ Date of discharge: (MM/DD/YY) \_\_\_\_ | \_\_\_\_ | \_\_\_\_

6. a) From what date did this condition prevent the Patient from traveling? (MM/DD/YY) \_\_\_\_ | \_\_\_\_ | \_\_\_\_  
b) On what date was this condition stable and controlled to permit travel? (MM/DD/YY) \_\_\_\_ | \_\_\_\_ | \_\_\_\_

7. If the Patient is not the Insured, from what date was travel precluded for the Insured due to the Patient's condition? (MM/DD/YY) \_\_\_\_ | \_\_\_\_ | \_\_\_\_

8. Did you advise the Patient/Insured to cancel travel plans prior to departure or return home early as a result of this condition?  Yes  No  
If Yes, on what date? (MM/DD/YY) \_\_\_\_ | \_\_\_\_ | \_\_\_\_ Please explain: \_\_\_\_\_  
If No, on what date was it reasonable for the Patient/Insured to Cancel/Interrupt their travel plans? (MM/DD/YY) \_\_\_\_/\_\_\_\_/\_\_\_\_

9. If condition was related to pregnancy, when was the pregnancy first diagnosed? (MM/DD/YY) \_\_\_\_ | \_\_\_\_ | \_\_\_\_  
Expected Delivery Date? (MM/DD/YY) \_\_\_\_ | \_\_\_\_ | \_\_\_\_

10. Was this injury or sickness the sole cause of the Patient's disability leading to Cancellation/Interruption?  Yes  No  
If No, please explain: \_\_\_\_\_

**Physician's Remarks:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Physician \_\_\_\_\_ Date Completed: \_\_\_\_ | \_\_\_\_ | \_\_\_\_  
Name of Physician: \_\_\_\_\_ Telephone No. ( \_\_\_\_ ) \_\_\_\_\_  
Address of Physician: \_\_\_\_\_ Fax No. ( \_\_\_\_ ) \_\_\_\_\_  
Taxpayer Identification No. \_\_\_\_\_

Patient's full name at time of treatment: \_\_\_\_\_

Date of birth: (MM/DD/YY) \_\_\_\_ | \_\_\_\_ | \_\_\_\_

Address: \_\_\_\_\_

Purpose of release: **ADJUDICATION OF TRAVEL INSURANCE CLAIM**

**Effective Date of Insurance Coverage:** (MM/DD/YY) \_\_\_\_ | \_\_\_\_ | \_\_\_\_

Medical Facilities: (List all doctors consulted for this condition and hospitals where confined)

Name	Address	Telephone No.	Fax No.	Dates
_____	_____	_____	_____	____   ____   ____
_____	_____	_____	_____	____   ____   ____
_____	_____	_____	_____	____   ____   ____

You are authorized to give Transamerica Casualty Insurance Company and its affiliates, reinsurers, agents, consumer reporting agency, or independent claims administrator acting on behalf of Transamerica Casualty Insurance Company, any information concerning insurance coverage, medical care, advice, treatment or supplies, or any other information that may have bearing on the request for benefits submitted in conjunction with the travel insurance policy.

Information to be released:

**All medical records of the Patient for up to 180 days before the Effective Date of Insurance Coverage as shown above through the date of this consent as shown below as applicable based on the patients age as outlined the policy.** "Medical records" includes, without limitation, diagnosis list, medication list, physician dictation, office notes, physical therapy records, occupational therapy records, pathology reports, cytology reports and the results of all laboratory tests.

**Send to: Claims Administration Office For  
Transamerica Casualty Insurance Company  
4600 Witmer Industrial Estates, Suite 6  
Niagara Falls, NY 14305  
Telephone: 1-866-968-2061 Fax: 1-877-367-2496**

**By signing below, I understand that:**

1. The information in my health record may include information relating to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I have the right to revoke this consent at any time by providing my written revocation to the facility where my records are kept.
3. A revocation will not apply to information that has already been released in response to this consent.
4. A revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. Unless otherwise revoked, this consent will expire in six months.
6. Consenting to the disclosure of this health information is voluntary. I can refuse to sign this consent.
7. Any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I authorize Transamerica Casualty Insurance Company to disclose my health or claim information to any relevant source (e.g. airline, tour operator, travel suppliers, etc.) for the purpose of obtaining recoveries or any outstanding refunds after my insurance claim has been settled. I hereby assign to Transamerica Casualty Insurance Company any benefits or recoveries obtained from these sources for losses covered under this policy. I direct these sources to forward reimbursement to Transamerica Casualty Insurance Company with regard to these losses.

Signature of patient or authorized person: \_\_\_\_\_ Date: (MM/DD/YY) \_\_\_\_ | \_\_\_\_ | \_\_\_\_

Relationship/Reason patient is unable to sign: \_\_\_\_\_

**CLAIM FORM FRAUD REQUIREMENTS****\*\*MANDATORY: Please Read and Sign Below\*\*****All States Other Than Those Listed:**

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.

**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 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 Affairs.

**Delaware**

Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a claim containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia**

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 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 insurer files a statement or claim containing any false, incomplete or misleading information is guilty of a felony.

**Indiana**

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

**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.

**Louisiana**

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.

**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.

**Maryland**

Any person who, with intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

**Minnesota**

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**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 procedures.

**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**

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.

**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**

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.

**Washington**

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.

**I CERTIFY THAT I HAVE READ THE FRAUD STATEMENT THAT APPLIES TO MY STATE OF RESIDENCE. IF MY STATE OF RESIDENCE IS NOT LISTED, I CERTIFY THAT I HAVE READ THE "ALL OTHER STATES OTHER THAN THOSE LISTED"**

Signature

Date

( MM / DD / YY )