

Dear Policyholder:

Please complete and sign the attached claim form. Additionally, the following are items needed in order to process your **Travel Delay** claim in the most efficient and expedient way possible.

What you should provide:

- Documentation from the carrier regarding the date, reason for, and length of the delay;
- Actual proof of payment for your trip, such as credit card statements or copies of front and back of cancelled checks. Invoices will not be accepted as actual proof of payment;
- Proof of refunds received, such as credit card statements or copies of front of checks;
- Dated receipts for all additional hotel, phone, meal and local transportation expenses incurred, as daily and policy maximum limits apply;
- Proof of payment and receipts for additional transportation expenses;
- Proof of age for all travelers on the policy/certificate;
- Please provide the relationship of all insured parties making a claim. If any are minors, please provide the name and address of their parent or legal guardian;
- **EACH PARTY MAKING A CLAIM MUST SIGN THE COMPLETED CLAIM FORM.**

What your travel agent should provide if you are claiming unused expenses (To expedite your claim, if you have these documents, please provide them. If they are not in your possession, please try to obtain them from your travel agent and submit with your claim):

- All invoices and itineraries;
- All carrier and supplier cancellation policies (schedule of penalties) that applied to your trip;
- A separation of the amount paid for the land, cruise and air portions of your trip.

Thank you for this important information. Should you have any questions, please call us at (800) 541-3522.





TRIP CANCELLATION, INTERRUPTION, MISSED CONNECTION & TRAVEL DELAY CLAIM FORM



IMPORTANT: ALL PAGES OF THIS CLAIM FORM MUST BE COMPLETED IN FULL AND SIGNED. FAILURE TO DO SO MAY DELAY THE PROCESSING OF YOUR CLAIM.

SECTION 1: PERSONAL & TRAVEL INFORMATION

NAME OF INSURED		POLICY/REFERENCE #		TRAVEL DATES	
BOOKING/RESERVATION/CONTRACT #	DATE OF BIRTH	HOME PHONE	BUS/CELL PHONE	EMAIL ADDRESS	
INSURED MAILING ADDRESS		CITY	STATE	ZIP CODE	
CO-INSURED/TRAVELING COMPANION(S)	DATE OF BIRTH	HOME PHONE	BUS/CELL PHONE	EMAIL ADDRESS	
CO-INSURED/TRAVELING COMPANION(S) MAILING ADDRESS		CITY	STATE	ZIP CODE	
TRAVEL AGENT/RENTAL COMPANY	TRAVEL AGENT'S NAME	TELEPHONE	FAX	EMAIL ADDRESS	
TRAVEL AGENT'S MAILING ADDRESS		CITY	STATE	ZIP CODE	

SECTION 2: DETAILS OF LOSS

REASON FOR TRIP CANCELLATION, TRIP INTERRUPTION OR TRAVEL DELAY

DATE TRIP WAS CANCELLED, INTERRUPTED OR DELAYED

SECTION 3: AMOUNTS CLAIMED

DESCRIPTION/NAME OF SUPPLIER	AMOUNT PAID	AMOUNT REFUNDED TO YOU	AMOUNT CLAIMED
TOTAL AMOUNT CLAIMED:			

PLEASE COMPLETE OTHER SIDE

CSA TRAVEL PROTECTION • P.O. BOX 939057 • SAN DIEGO, CA 92193-9057 • PHONE (800) 541-3522 • FAX (877) 300-8670

FRAUD WARNINGS AND DISCLOSURES

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.

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.

Arkansas, New Mexico and Texas: 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.

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 any 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.

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

DC and Maine: 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 employer or employee, insurance company, or self insured program files a statement of claim or an application containing any false or misleading information commits insurance fraud, punishable as provided in section 817.234.

Kentucky and 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.

Louisiana and Rhode Island: 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.

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 false or misleading information is subject to criminal and civil 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 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 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.

Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to any insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

By checking this box, I/we attest that this claim is not being paid by any other carrier/insurer for considered claim payment, and I/We agree that my/our typed signature(s) be accepted as my/our written signature(s) and attest that all of the statements in this document are true and complete to the best of my/our knowledge. I/We authorize CSA Travel Protection to contact the insured to verify whether or not a loss has occurred during their stay, and I/we further authorize CSA Travel Protection to release and share claim information including that which may be used in the identification and prevention of potential fraudulent activity to Generali US Branch, Stonebridge Casualty Insurance Company, United States Fire Insurance Company, insurance support organizations, fraud information clearinghouses, designated service providers and business associates assisting in the processing of the claim.

INSURED'S SIGNATURE

PRINT NAME

DATE

ADDITIONAL INSURED SIGNATURE

PRINT NAME

DATE

SECTION 4: PHYSICIAN'S STATEMENT (TO BE COMPLETED BY PHYSICIAN ONLY)**PATIENT INFORMATION**

Patient's Name

Date of Birth

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

Name

Phone

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

 YES NO**PATIENT'S DIAGNOSIS**

Diagnosis

ICD Code

On what date did the symptoms/injury first appear?

Did you perform an actual examination?

Date of initial examination:

 YES NO

Please list all dates of examination and treatment

Is this condition a complication of an underlying condition? If yes, please explain

 YES NO

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

How long will the patient be disabled?

Did you advise that the trip should be cancelled or interrupted due to the patient's medical condition? If yes, what date?

 YES NO

DATE _____

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

BY MY SIGNATURE AND STAMP BELOW, I HEREBY CERTIFY THAT THE ABOVE IS TRUE AND CORRECT.

Physician Signature

Tax ID

Date