CSA TRAVELPROTECTION
A Europ Assistance Group Company

Dear Policyholder:

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

What you should provide:

- A signed and completed "Patient's Authorization". Regulations under HIPAA (Health Information Portability and Accountability Act) were enacted nationwide by doctors' offices, hospitals and other health care providers. As a result, we must request that the patient or their authorized legal representative sign and complete the enclosed form in its entirety. Authorized legal representatives must include a copy of their designation as such. **Failure to provide this documentation may result in a delay of your claim;**
- A copy of the patient's death certificate (the certificate must state cause of death). In some instances, medical records pertaining to the patient's sickness or injury may be requested upon review of the claim;
- Proof of payment and receipts for any additional transportation expenses incurred;
- Dated receipts for additional hotel, phone, meal and local transportation expenses incurred, as daily and policy maximum limits apply;
- 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;
- 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.

Patient Authorization Form

Name of Patient:_____ Date of Birth:_____
SS#:_____ Purpose of release: TRAVEL INSURANCE CLAIM

DOCTORS AND/OR MEDICAL FACILITIES AUTHORIZED TO RELEASE MY HEALTH INFORMATION:

Name	Address	Telephone	Fax	Dates Treated

You are authorized to release any health information that may have bearing on the request for benefits submitted in conjunction with the travel protection plan to: CSA Travel Protection and Insurance Services, its affiliates, underwriters, reinsurers, and any agent expressly acting on behalf of CSA Travel Protection and Insurance Services. Additionally, if there is potential fraudulent activity you release medical information related to the identification and prevention of the fraudulent activity to the underwriters, insurance support organizations, fraud information clearinghouses and designated service providers assisting in the processing of the claim.

Send to: CSA Travel Protection and Insurance Services
Attn: Claims Department, P.O. Box 939057, San Diego CA 92193-9057
FAX: 877-300-8670. Information to be released: Physician Dictation, Physical and/or Occupational Therapy Records, Office Notes, Lab Reports, Entire Record,
Other: _____

I UNDERSTAND THE FOLLOWING:

- If applicable, HIV/AIDS, genetic testing, abuse, drugs/alcohol and/or mental health records will be included in the health information that is released.
- I may revoke this authorization to the health information management department in writing. My revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless revoked, this authorization will expire in six months.
- I may inspect or copy the information to be used or disclosed, as provided in CFR164.524. 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 am entitled to a copy of this authorization. A facsimile or photocopy can be treated as the original.
- THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.
- My treatment, payment, or enrollment may not be conditioned on signing this authorization. If I refuse to sign this authorization, benefits may not be paid under the travel protection plan if additional health information is needed to determine my eligibility for benefits.

Signature of patient or authorized person Date:

Relationship/Reason patient is unable to sign

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

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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?	Name	Phone	Was the patient referred to you by the primary care physician?
☐ YES ☐ NO			☐ 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