Global Assistance

Allianz

Claim Form

General Information

Contact Information

Name of insured: _____

Social Security Number _____--_____--_____

Home telephone: (____) _____--_____

Date of birth:_____

Work telephone: (____) _____--_____

E-mail address: _____

Home Address

Street:_____

City:_____ State:____ Zip:_____

Mailing Address, if different from Home Address

Street:_____

City:_____ State:_____ Zip:_____

Preferred method of contact: Mail ☐ E-mail ☐ Home Phone ☐ Work Phone ☐

Plan Information

Confirmation/Policy ID #: _____

or Product ID #: _____

or Group #:_____

or Company ID #: _____

or Membership #:_____

Reference #: _____

Trip Information

Departure Date: _____

Return Date: _____

Original destination: _____

Travel agency name: _____

Date of initial deposit/payment:

Agent's name: _____

Agent's phone number: (_____) _____ -- _____

Agent's e-mail address: _____@_____

Traveling Companions *(please indicate name and relationship to you)*

1. _____

2. _____

3. _____

4. _____

Claim Information

Reason for filing this claim (short description) _____

_____

_____

_____

Date incident occurred: ____ / ____ / _____

Do you have other insurance that may cover this event?

Yes ☐ No ☐

If Yes, then please provide the name of the insurance company _____

E-mail to: 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

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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):

_____

_____

_____

_____

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

- 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.

☐ Non-Medical

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

* 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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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: ___ / ___ / _____

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.

_____

_____

_____

_____

_____

☐ No

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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