

## **Claim Form**

## **General Information**

Contact Information		
Name of insured:	Social Security Number	
Date of birth:	Home telephone: ()	
Place of birth:	Work telephone: ()	
	E-mail address:@	
Home Address	Mailing Address, if different from Home Address	
Street:	Street:	
City: State: Zip Code:	City: State: Zip Code:	
Preferred method of contact: Mail   E-mail	Home Phone  Work Phone	
Plan Information	Trip Information	
Confirmation/Policy ID #:	Departure date:	
or Product ID #:	Return date:	
<u>or</u> Group #:	Original destination:	
or Company ID #:	Travel agency name:	
or Membership #:	Date of initial trip deposit/payment://	
	Agent's name:	
	Agent's phone number: ()	
	Agent's e-mail address:@	
Traveling Companions (please indicate name and relations	hip to you)	
1	3	
2	4	
Claim Information		
Reason for filing this claim (short description)		
	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@accessamerica.com

Mail to: ACCESS AMERICA, 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 World Access Service Corp., a company of Mondial Assistance



# **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 inter	rupted this trip?			
☐ Yes Date	□ No	o			
Was the reason for the trip cancellation, interruption, or delay of a <b>medical</b> or <b>non-medical</b> nature?					
☐ Medical		☐ Non-Medical			
<ul> <li>Please complete this entire form.</li> </ul>					
<ul> <li>Attach the enclosed Physician Statement Form completed by an appropriate physician.</li> </ul>	Please skip to the <i>Claimed Expenses</i> section below.				
If your cancellation, interruption, or delay was due to someone's death, please attach a copy of the death certificate.					
	•				
Details of Medical Condition					
Name of patient: Relationship to		named insured:			
Nature of medical condition:	Date condition first began:				
	Date of first treat	ment:			
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 (Please enclose a copy)	□ No		
Please list doctors consulted for this condition.		(			
Name Address		Phone	Last seen on		
1		()	//		
2		()	//		
3		()	//		

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Claimed Expenses			
<u>Category</u>	<u>Amount</u>	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	\$		

<sup>\*</sup> 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 World Access Service Corp., claim administrator, or its authorized representatives for the purpose of evaluating and determining coverage for this claim.

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:	

The status of your claim can be easily viewed at www.eclaimsline.com/travel by clicking on the "Check Claim Status" link.

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