

# Trip Claim Form

## Step 1 – Choose the Type of Claim

**Trip Cancellation** I am unable to leave on my trip due to an unforeseen event and want to request reimbursement for non-refundable trip payments and deposits.

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**Trip Delay** I had an unforeseen delay that caused me to have additional out-of-pocket expenses such as unplanned hotel accommodations, meals, and local transportation.

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**Trip Interruption** I had an unforeseen interruption that caused me to have unused, non-refundable portions of my trip and/or caused me to purchase new or additional airline, bus, or train tickets.

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Provide copies or photos of any documentation that supports the reason for your claim.

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Provide copies or photos of receipts or credit card statements for out-of-pocket expenses.

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**Scan/Upload:**

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**Mail to:**

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**Email to:**

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**Fax to:**

If you have questions about your claim, our customer service team is available by phone at \_\_\_\_\_, or,



## Claim is Related to a Medical Situation

If claim is not related to a medical situation, do not complete this section.

## To be completed by Patient / Guardian

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Patient's name (First and Last)

Date of Birth (mm/dd/yyyy)

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Insured's name (First and Last)

Insured's relationship to patient

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Policy purchase date (mm/dd/yyyy)

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## To be completed by Physician (This information will be used for the adjudication of travel insurance claims)

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1. Was the patient medically stable for travel on the policy purchase date noted above? YES  
(If NO, please provide medical records from the policy purchase date to the present.) NO

2. Primary Diagnosis

Secondary Diagnosis

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3. When did symptoms first appear or injury occur? (mm/dd/yyyy)

4. Provide the dates of treatment, primary/secondary diagnosis and treatment provided.

### Primary Diagnosis

Date of Treatment (mm/dd/yyyy)

Describe the treatment/condition for this date

a) \_\_\_\_\_

a) \_\_\_\_\_

b) \_\_\_\_\_

b) \_\_\_\_\_

c) \_\_\_\_\_

c) \_\_\_\_\_

### Secondary Diagnosis

Date of Treatment (mm/dd/yyyy)

Describe the treatment/condition for this date

a) \_\_\_\_\_

a) \_\_\_\_\_

b) \_\_\_\_\_

b) \_\_\_\_\_

## Claim is Related to a Medical Situation

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