TRIP DELAY CLAIM FORM

PRIMARY INSURED INFORMATION:

ID Number:	**Date of Birth:** M/D/Y	
Name of the claimant:		
Work Phone:	**Home Phone #:**	
Email:	**Social Security Number:**	
Complete Mailing Address:	**City, State:**	**Postal Code:**

TRANSPORTATION PROVIDER:

Company Name:		**Address:**		
City:	**State:**	**Zip:**	**Contact:**	**Phone #:**
Travel Arrangements Dates: M/D/Y		**Date of initial payment deposit:** M/D/Y		
Scheduled Date of Departure: M/D/Y		**Scheduled Date of Return:** M/D/Y		
If not included in package, how was air travel arranged?				

LOSS INFORMATION:

After completing this section, attach copies of all travel documents (original airline tickets, hotel receipts, travel itinerary, tour cost, etc.) supporting penalties, added costs or nonrefundable charges incurred by you due to cancellation, Trip delay or disruption.

Company name: (airline / hotel / cruise / travel agent / etc.)	Amount paid:	Amount of loss: (non-refundable amount)	Have you received reimbursement?	If so, from whom?	How much?
	$	$	Yes ☐ No ☐		$
	$	$	Yes ☐ No ☐		$
	$	$	Yes ☐ No ☐		$
	$	$	Yes ☐ No ☐		$
Total	$	$			$

REASON FOR DELAY:

Cancellation Date / Notice / Delay: M/D/Y		**Place:**
Duration:	**Hours:**	**Min:**
Name of party involved:		**Relationship to Primary Plan Participant:**
Reason for Cancellation / Delay / Disruption:		

IF CANCELLATION / DELAY / DISRUPTION DUE TO MEDICAL REASONS:

Name of person having sickness or injury:	
His / Her date of birth: M/D/Y	**His / Her relationship to claimant:**
Date Sickness or Injury began: M/D/Y	**Date ended:** M/D/Y
Nature of Sickness or Injury (If Injury, describe accident, including date and place):	
Dates of hospitalization (If applicable): From: M/D/Y	**To:** M/D/Y

To Be Completed by the Attending Physician

Name of Doctor:	**Address:**
Office Phone #:	**Fax:**
Name of patient:	**Age:**
Date symptoms first appeared or accident occurred: M/D/Y	
Date of first Treatment: M/D/Y	**Was patient treated by someone else?:** ❑YES ❑NO
If so, by whom:	**When:** M/D/Y
Did you prohibit patient's traveling by air or otherwise due to this injury / illness?: ❑YES ❑NO	
Has the patient received medication or other treatment for this condition, or for a related condition, by you or any other Physician during the 90 days immediately prior to the date the claimant purchased this Travel medical plan (see page 1 for date of purchase)? If so, please provide exact dates and details:	

Any false or misleading statements made in support of and resulting in the payment of a claim shall be subject to legal action for collection of damages to the insurance company against the person or persons making such false and or misleading statements.

Physicians
Signature: _____ **Date**: M/D/Y _____

Taxpayer ID Number: _____

Authorization For Release of Medical Information — To be Completed by Patient

In order to process a claim for benefits, I authorize any physician, hospital, or other Medical Provider to release to Azimuth Risk Solutions, LLC, or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed two and one-half years from the date signed. I understand I have a right to receive a copy of this authorization.

Signature: _____ **Date:** M/D/Y _____
(Signature of Person Suffering Illness or Injury or legally authorized representative)

DOCUMENTATION REQUIREMENTS:

Depending upon the circumstance involved in the loss, one or more of the following items may be required to complete the processing of your claim. Please place a check by those items you have attached. We recommend you keep copies of any items submitted with this claim.

- ☐ Airline Ticket Stub/Receipt

  Note: Only original, paper tickets can be reimbursed. If you received E-tickets, you *must* have them issued at a ticket counter and submit them to be considered for reimbursement. Contact the airline for more information.

- ☐ Copies of cancelled checks or credit card statements within an invoice from your Travel Provider showing the date of your deposit. If you seek to waive the pre-existing condition exclusion on your claim, you *must* submit proof of insurance purchase within 10 days of making your initial trip deposit.
- ☐ Police Report
- ☐ Statement from Hotel/Motel, Airline Carrier or Airport Facility that concerns your Cancellation/Delay. **Note:** Any cancellation or delay of flight must be documented by the airline.
- ☐ Car Rental Agreement
- ☐ **Copies of reimbursement statements issued by an airline carrier, airport facility, car rental agency, travel agent, hotel/motel or other similar establishment or any other insurance company providing reimbursement to you for the loss.**
- ☐ Other (please describe):

OTHER INSURANCE / AUTHORIZATION:

Do you have any other type of insurance? ☐YES ☐NO

If so, please provide the Company Name and Address: _____

_____

Type of Policy: _____ **Policy #:** _____ **Contact**: _____ **Phone:** _____

I AUTHORIZE any insurance company, physician, hospital, and other health care providers, any travel organization or agency, airline carrier, rental agency, hotel, motel, or similar entity providing lodging on a rental/lease basis or any other person who may have knowledge regarding this claim, to release any information requested regarding this claim and the loss reported.

I UNDERSTAND that The Beacon Series Travel Medical Plan, administered by Azimuth Risk Solutions, LLC, does not cover losses caused by injury or sickness to the extent that they are eligible under this travel medical insurance policy wording, now therefore, as a condition for my receipt of immediate benefits under the Beacon Series plan, for claims in connection with injury or sickness beginning on the date shown above, I irrevocably agreed to: (a) assign all benefits payable from my primary insurer to Azimuth Risk Solutions, LLC; (b) promptly reimburse Azimuth Risk Solutions, LLC if and when I receive payment(s) from my primary insurance; (c) allow Azimuth Risk Solutions, LLC to file a claim with my primary insurer to receive direct reimbursement; and (d) when requested by Azimuth Risk Solutions, LLC, to furnish Azimuth Risk Solutions, LLC with copies of my primary insurer's schedule of benefits.

I UNDERSTAND the information obtained by use of the authorization, will be used by Azimuth Risk Solutions, LLC to determine eligibility for benefits under this plan. Any information obtained will not be released by Azimuth Risk Solutions, LLC to any person or organization

EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I further authorize.

I KNOW that I may request to receive a copy of the Authorization. I AGREE that a photographic copy of this authorization is as valid as the original. I UNDERSTAND that it is illegal to knowingly file a false or fraudulent claim or to knowingly help someone else file a false or fraudulent claim. I have read and understand the Fraud Notices in this document.

Signature: _____ Date: M/D/Y _____

Mailing Instructions:
Send this form and any
accompanying documentation to:

Azimuth Risk Solutions, LLC
P. O. Box 627
Indianapolis, IN 46206
Phone: 317-644-6291/888-201-8850
Fax: 317-423-9620/888-201-8851