

**Allianz** 

Global 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 interrupted this trip?

☐ Yes Date _____☐ No

Was the reason for the trip cancellation, interruption, or delay of a **medical** or **non-medical** nature?

☐ Medical☐ Non-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.

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. _____	_____	() ____ - ____	____/____/____

E-mail to: claims inquiry@allianzassistance.com

Mail to: Allianz Global Assistance, P.O. Box 72031, RICHMOND, VA 23255-2031

Call: 1-800-892-0130 Fax to: 804-673-1469. We are available 24 hours a day.

Insurance underwritten by Jefferson Insurance Company
Plan administered by AGA Service Company

Claimed Expenses

<u>Category</u>	<u>Amount</u>	<u>Required Supporting Documentation*</u>
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	\$ _____	<i>Examples:</i> 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.

ALABAMA FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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 a 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.

MARYLAND FRAUD WARNING: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in 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 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: _____

The status of your claim can be easily viewed at www.allianztravelinsurance.com, by clicking on the "Claim Status" link.

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Physician Statement Form

To be completed by Primary Insured

Primary Insured's Name: Nicole Brower

Policy Number: EUSP2067534279

Insurance Purchase Date: February 24, 2016

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 / ICD-10 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: ____ / ____ / ____

☐ No

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.

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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Nicole Brower
3075 Ridgeview Drive
El Dorado Hills, CA 95762
USA

Required General Documentation

So that we may begin processing your claim, please locate the type of claim you are filing and submit the applicable documentation listed below. Please be advised that we reserve the right to request additional information or documentation.

Trip Cancellation due to Medical Reasons

- **General Claim Form**
- **Completed Physician Statement Form** - Please note that in some cases you may submit a doctor's letter or hospital admission/discharge papers; however, we may still require that you submit a completed physician statement form if we do not receive the information that we need to process your claim.
- **Proof of Payment** - For all trip expenses being claimed, we require complete proof of payment. If payment was made by credit card, a copy of the charge is requested. For payments made by check, we require front and back copies of each check.
- **Trip Invoice/Itinerary** - Please submit your complete Cruise Invoice, Tour Invoice, or your Airfare Itinerary (*whichever may apply*) listing a \$0.00 balance, your travel dates and names of travelers.
- **Penalty/Refund information** - When cancelling your trip, you may be entitled to a partial refund from the travel supplier at the time of your cancellation. You will need to contact your travel agent and request either a cancellation invoice from the travel supplier, or a letter on letterhead from your travel agent verifying any refunds received.

Trip Cancellation due to Nonmedical Reasons

- **General Claim Form**
- **Documentation Reflecting the Reason for Cancellation** - This is a named perils policy. Coverage can only be provided if your cancellation is for one of the outlined reasons within your Certificate of Insurance. (*For example, if you are subpoenaed to court, a copy of your subpoena is required, etc.*)
- **Proof of Payment** - For all trip expenses being claimed, we require complete proof of payment. If payment was made by credit card, a copy of the charge is requested. For payments made by check, we require front and back copies of each check.
- **Trip Invoice/Itinerary** - Please submit your complete Cruise Invoice, Tour Invoice, or your Airfare Itinerary (*whichever may apply*) listing a \$0.00 balance, your travel dates and names of travelers.
- **Penalty/Refund information** - When cancelling your trip, you may be entitled to a partial refund from the travel supplier at the time of your cancellation. You will need to contact your travel agent and request either a cancellation invoice from the travel supplier, or a letter on letterhead from your travel agent verifying any refunds received.

Trip Interruption due to Medical Reasons

- **General Claim Form**
- **Medical Documentation** - Documentation verifying the illness or injury that caused you to interrupt your trip, i.e., hospital admission discharge papers or a completed Physician Statement Form.
- **Proof of Payment** - For all trip expenses being claimed, we require complete proof of payment. Any additional transportation expenses or meals will require receipts. Change fees or additional airfare purchased will require proof of payment. Hotel stays will require a copy of the invoice.
- **Trip Invoice/Itinerary** - If your Trip Interruption has caused you to miss a portion of your Cruise, or any Tours that you may have booked, we will need a copy of the invoice so that we may prorate your portions missed.
- **Penalty/Refund information** - If you have booked tours or land excursions that you were not able to use, please note that you may be entitled to a refund for the unused portions. You will need to contact your travel agent and request this information.

Trip Interruption due to Nonmedical Reasons

- **General Claim Form**
- **Documentation Reflecting the Reason for the Interruption** - This is a named perils policy. Coverage can only be provided if your cancellation is for one of the outlined reasons within your Certificate of Insurance. *(For example, if your interruption is caused by your common carrier, you will need to obtain a statement from the common carrier verifying the cause and duration of the interruption, etc.)*
- **Proof of Payment** - For all trip expenses being claimed, we require complete proof of payment. Any additional transportation expenses or meals will require receipts. Change fees or additional airfare purchased will require proof of payment. Hotel stays will require a copy of the invoice.
- **Trip Invoice/Itinerary** - If your Trip Interruption has caused you to miss a portion of your Cruise, or any Tours that you may have booked, we will need a copy of the invoice so that we may prorate your portions missed.
- **Penalty/Refund information** - If you have booked prepaid Trip Expenses, i.e., Tour, Cruise, etc., and you have missed a portion booked, please note that you may be entitled to a refund for the unused portions. You will need to contact your travel agent and request this information.

Medical Expenses

- **General Claim Form**
- **Medical Bills** - Copies of the medical bills you received. *(Please note that coverage may be secondary to your primary/supplemental insurance. Please review your Certificate of Insurance / Policy for verification. If your policy is secondary in coverage, you will need to file a claim with your primary/supplemental insurance.)*
- **Notarized Statement of No Insurance** - If you have a policy that is secondary in coverage and you do not have any primary or supplemental insurance, we will need a notarized letter that states this fact.

Baggage Coverage (Lost, Damaged, or Stolen)

- **General Claim Form**
- **Common Carrier Claim Form/Determination** - If your baggage is damaged or lost by the travel supplier, you will need to notify and file a claim with the supplier. We are **secondary** in coverage and will require a claim form and the determination before we can move forward with your claim.
- **Incident Report** - If your baggage is stolen, we require a copy of the report made to the authorities when the theft occurred.
- **Receipts** - You will need to provide receipts for any items being claimed that are lost, damaged or stolen.

Baggage Delay

- **General Claim Form**
- **Bag Irregularity Report** - This is a copy of the report you receive when you notify the travel supplier that your bags have been delayed.
- **Receipts** - Copies of the receipts for purchases of necessary items due to your bags being delayed. *(Please note that **without** receipts for your claimed expenses, we will be unable to consider your expense for coverage.)*

Travel Delay

- **General Claim Form**
- **Proof of Payment** - For all trip expenses being claimed, we require complete proof of payment. Any additional transportation expenses or meals will require receipts. Change fees or additional airfare purchased will require proof of payment. Hotel stays will require a copy of the invoice.

Missed Connection

- **General Claim Form**
- **Proof of Payment** - For all trip expenses being claimed, we require complete proof of payment. Any additional transportation expenses or meals will require receipts. Change fees or additional airfare purchased will require proof of payment. Hotel stays will require a copy of the invoice.
- **Documentation Reflecting the Reason for the Missed Connection** – This is a named perils policy. Coverage can only be provided if your missed connection is for one of the outlined reasons within your Certificate of Insurance. *(For example, if your missed connection is caused by your common carrier, you will need to obtain a statement from the common carrier verifying the cause and duration of the delay.)*

Collision Loss Damage

- **General Claim Form**
- **Rental Car Agreement** - This document should be provided by the agency when you pick up the car. You should be provided with a closed rental car agreement upon returning the car.
- **Repair Bill**
- **Itinerary/Invoice for Rental Car Reservation** - This document should include the dates for the rental car as well as the amount paid for the reservation.
- **Police Report**

The documents and information may be mailed or faxed to:

Allianz Global Assistance
Attn: Travel Claims Dept.
P.O. Box 72031
Richmond, VA 23255-2031
Fax: (804) 673-1469

If you need additional information, please call us at 1-888-358-4239.

How can we help?

Claim Form

General Information

Contact Information

Name of insured: Nicole Brower	Social Security Number XXX--____--____
Home telephone:	Date of birth:
Work telephone:	E-mail address: _____@_____
<i>Home Address</i>	<i>Mailing Address, if different from Home Address</i>
Street: 3075 Ridgeview Drive	
City: El Dorado Hills State: CA Zip: 95762	City: _____ State: _____ Zip: _____
Preferred method of contact: Mail <input type="checkbox"/> E-mail <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/>	

Plan Information

Confirmation/Policy ID #: EUSP2067534279

or Product ID #: 001002847

or Group #:

or Company ID #: 22008

or Membership #:

Reference #:0003729606

Trip Information

Departure Date: April 14, 2016

Return Date: April 18, 2016

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. _____	3. _____
2. _____	4. _____

Claim Information

Reason for filing this claim (short description) _____	Date incident occurred: ____ / ____ / ____
_____	Do you have other insurance that may cover this event?
_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	If Yes, then please provide the name of the insurance company _____

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