CARD BENEFIT SERVICES

CASE ID: 5675140
DATE SENT: 7-9-2018

P. O. Box 72034
Richmond, VA 23255
eclaimsline@eclaimsline.com

Nelly Ackerman
7835 Brookwood Way
Cumming, GA 30041-8350
USA

For Faster Service

Visit **eclaimsline.com** to
- Access a claim form
- Check the status of your claim

Dear Nelly Ackerman,

Thank you for being a valued cardholder and for contacting Card Benefit Services about your Trip Cancellation/Trip Interruption Benefit.

This benefit is intended to supplement any applicable insurance or other reimbursement you receive from the Common Carrier or other party. It applies only to the amount not payable by insurance or other reimbursement.

For claim eligibility, ***your notification date needs to be within 20 days of the Trip Cancellation/Trip Interruption or as soon as reasonably possible.***

If the incident you experienced meets these criteria and falls within the eligibility period, **you must send us a completed claim form and all supporting documentation within 90 days of the Trip Cancellation/Trip Interruption or as soon as reasonably possible.**

Immediate Next Steps

1) **Return your completed and signed claim form** using your preferred method below:
   - **ONLINE.** Access and submit an online form by visiting **eclaimsline.com.**
   - **EMAIL.** Submit an electronic claim form to **eclaimsline@eclaimsline.com.**
   - **MAIL.** Use the enclosed form and return it in the envelope provided. Make any necessary changes to the pre-filled information directly on the form.

2) **Include these documents with your claim form:**
   - ☐ Copy of the cardholder's monthly billing statement (showing the last 4 digits of the account number) confirming the travel fare was charged to the covered account
     - If more than one method of payment was used, please provide documentation as to additional currency, voucher, points or any other payment method utilized

Continued on next page

- ☐ Copy of the detailed original and updated travel itinerary and/or the Common Carrier tickets (at least one of the documents must reflect the total amount charged for the claimed trip)
- ☐ Confirmation of the reason for the Trip Cancellation or Trip Interruption (i.e., medical documents, death certificate, or other documentation supporting the Covered Loss)
    - Please note, you are responsible for any costs associated with obtaining documentation to substantiate your claim
- ☐ Copy of the cancellation or refund policies of the Common Carrier, Tour Operator, or Travel Supplier
- ☐ Copy of the settlement response from the Common Carrier or other party outlining the claim payment breakdown. If the Common Carrier or other party denied payment for this loss, please provide a copy of the denial response
- ☐ Proof of expenses incurred due to a Trip Cancellation/Trip Interruption (if applicable)

*NOTE: You are responsible for obtaining all required documentation. Please complete, sign and return the claim form right away, even if you haven't obtained all of the documents requested. You must postmark your claim form and documents within **90 days** of the date of loss or as soon as reasonably possible.*

3) Keep a copy of your completed claim form and all documents you provide.

For questions or assistance, feel free to call us 24 hours a day:

- 1-800-356-8955 within the U.S.
- 1-804-673-1691 outside the U.S. (please call collect)

We appreciate your business and welcome this opportunity to service you.

Thank you,

Card Benefit Services

Enclosure(s)

USBC_ENG_CH_TCAN_CL

TRIP CANCELLATION/TRIP INTERRUPTION CLAIM FORM

Please Direct All Responses and Inquiries To:
P.O. Box: 72034
RICHMOND, VA 23255
TELEPHONE: 1-800-348-8472
OR CALL COLLECT: 1-804-673-1164
eclaimsline@eclaimsline.com

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THIS CLAIM FORM AND REQUIRED DOCUMENTS MUST BE POSTMARKED WITHIN 90 DAYS FROM THE DATE OF LOSS OR AS SOON AS REASONABLY POSSIBLE

SECTION 1 – GENERAL INFORMATION – COMPLETE ENTIRESECTION (PLEASE TYPE OR PRINT)

First Name: **Nelly**	Primary Telephone: **347/400-5470**	
Last Name: **Ackerman**	Alternative Telephone:	
Middle Name:	Email Address: **pavel.ack@gmail.com**	
Address: **Cumming GA 30041-8350**	Last 4 digits of Card #:	
	Date trip was booked:	
	Scheduled departure date:	Date trip was cancelled (MM/DD/YY):
	Scheduled return date:	
Number of people for whom travel was booked:	Departure Airport:	Arrival Airport:
Name of *Insureds whose travel was affected (List by Name):	Relationship to Cardholder (Include date of birth for dependent children):	
*Additional documentation may be required to confirm the relationship of the affected person(s) to cardholder.		

SECTION 2 – STATEMENT OF LOSS

Please provide the specific circumstances which caused your trip cancellation or trip interruption:

NOTE: If your claim is the result of sickness or injury to you, a family member, a traveling companion, or a traveling companion's family member, please also complete SECTION 4 of this form.

Who was notified of the cancellation? Please provide the name and phone number of travel agent, airline, cruise line, tour operator, etc:

Please identify the flight number, train or cruise number, etc:

Have you applied for or been given credit or other arrangements as reimbursement for your loss? ☐ Yes ☐ No

If yes, please provide details:

Do you have any other insurance that may provide coverage for this loss? ☐ Yes ☐ No

If yes, please provide the following for all other insurance (homeowners, travel club, etc). If you do not have any other insurance that would cover this loss, please complete SECTION 3 of this form.

Insurance Company Name	Address	Policy Number

SECTION 3 – CERTIFICATION OF NO OTHER INSURANCE

I, _____, hereby certify that I have no homeowner, renter, or any other travel insurance covering this loss and further attest that I have not submitted a claim for this loss under any other policy.

Signed (Insured or Authorized Person): Date:

SECTION 4 – ILLNESS, INJURY OR DEATH CLAIM DETAILS – ONLY COMPLETE IF APPLICABLE

Name of sick or injured person:	Relationship to you:

Nature of sickness or injury (If injury, please provide date, time, place, and circumstances of accident):

Date sickness or injury began (MM/DD/YY):	If hospitalized, dates confined (MM/DD/YY): _____ to _____
Date sickness or injury ceased (MM/DD/YY):	
Date of first treatment (MM/DD/YY):	

Please list the names and addresses of all treating/consulting physicians or healthcare providers below.

Physician or Healthcare Provider Name	Address

If hospitalized, please provide name and address of hospital(s) where treatment was received below.

Hospital Name	Address

Was sickness or injury the sole cause of your trip cancellation or trip interruption? ☐ Yes ☐ No

If no, please provide details:

If your claim is the **RESULT OF THE DEATH** of a family member, traveling companion, or traveling companion's family member, please complete the following:

Name of Deceased:	Relationship to you:	Date of death:

SECTION 5 – LOSS INFORMATION (PLEASE ATTACH A SEPARATE SHEET IF NECESSARY)

Please itemize total amount claimed below.

Description	Purchase Date	Name of Common Carrier/Hotel/Tour Operator or Other Vendor	Date of Travel/Stay	Original Purchase Price	Pending/Received Credit or	Non-refundable Amount Claimed
					Total amount claimed:	

SECTION 6 – IMPORTANT: PLEASE READ AND SIGN

WE ARE REQUIRED TO INFORM YOU OF THE FOLLOWING:

I understand that this claim form must be completed and that all required insurance, police and claims reports must be filed and submitted before any claim under the Trip Cancellation/Trip Interruption Benefit can be processed and paid. I authorize the issuing bank to release to the Benefit Administrator, all information regarding my account for the processing of this claim. I further authorize the Benefit Administrator to obtain copies of any police, fire or other investigative reports and information needed to process my claim. By signing this claim form I certify that the claim information stated above is true and correct to the best of my knowledge and belief. Any pre-printed information which was not pre-printed correctly has been corrected.

SIGNATURE:_____ **DATE:** _____

TRIP CANCELLATION/TRIP INTERRUPTION ATTENDING PHYSICIAN STATEMENT

THIS FORM IS REQUIRED IF THE CLAIM IS THE RESULT OF SICKNESS OR INJURY TO THE CARDHOLDER, A FAMILY MEMBER, A TRAVELING COMPANION, OR A TRAVELING COMPANION'S FAMILY MEMBER

Please Direct All Responses and Inquiries To:
P.O. Box: 72034
RICHMOND, VA 23255
TELEPHONE: 1-800-348-8472
OR CALL COLLECT: 1-804-673-1164
eclaimsline@eclaimsline.com

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SECTION 1 – GENERAL INFORMATION – TO BE FILLED OUT BY CARDHOLDER (PLEASE TYPE OR PRINT)

First Name: **Nelly**	Primary Telephone: **347/400-5470**
Last Name: **Ackerman**	Alternative Telephone:
Middle Name:	Email Address: **pavel.ack@gmail.com**
Address:	Last 4 digits of Card #:
	Date trip was booked:
Cumming GA 30041-8350	Patient Name: / Relationship to Cardholder:

SECTION 2 – CLAIM INFORMATION – TO BE FILLED OUT BY ATTENDING PHYSICIAN

Date of accident, injury, or illness (MM/DD/YY):	Date of first treatment or onset (MM/DD/YY):

Please describe the nature of the patient's injuries or illness:

Was this a referral from another doctor? ☐ Yes ☐ No

If yes, date of referral (MM/DD/YY):

Was the patient hospitalized? ☐ Yes ☐ No

If yes, please list the names and locations of all hospitals and all admission/discharge dates:

Hospital Name	Location	Adm. Date	Dis. Date

Was the patient recommended by you to curtail their trip/travel due to this condition? ☐ Yes ☐ No

If yes, travel restriction dates advised (MM/DD/YY): _____ to _____

Did this travel restriction affect any other family members or travel companions? ☐ Yes ☐ No

If yes, why did family member/travel companion need to curtail their travel?

Did the patient have any condition (including pregnancy) prior to trip booking that contributed to their present condition? ☐ Yes ☐ No

If yes, please describe:

At what date did patient originally begin treatment with this previous condition (MM/DD/YY): _____

Was the patient's previous condition stable at least 60 days prior to booking the trip? ☐ Yes ☐ No

Please describe:

For pregnancy, provide EDC (MM/DD/YY): _____ ☐ Not Applicable

SECTION 3 – ATTENDING PHYSICIAN INFORMATION – TO BE FILLED OUT BY ATTENDING PHYSICIAN

Name of Attending Physician:

Phone Number:

Address:

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete, or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Attending Physician): **Date (MM/DD/YY):**

IMPORTANT NOTICE

Notice to Alaska Claimants: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Notice to Arizona Claimants: For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Notice to Arkansas Claimants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to California Claimants: For your protection, California law requires the following to appear on this form: 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.

Notice to Colorado Claimants: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties many include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to Delaware Claimants: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.

Notice to District of Columbia Claimants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Notice to Florida Claimants: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information, is guilty of a felony of the third degree.

Notice to Idaho Claimants: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information, is guilty of a felony.

Notice to Indiana Claimants: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Notice to Kentucky Claimants: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Notice to Maine Claimants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Notice to Maryland Claimants: 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.

IMPORTANT NOTICE

Notice to Minnesota Claimants: A person who submits an application or files a claim with intent to defraud or helps commits a fraud against an insurer is guilty of a crime.

Notice to New Hampshire Claimants: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Notice to New Jersey Claimants: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Notice to New Mexico Claimants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Notice to New York Claimants: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Notice to Ohio Claimants: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Oklahoma Claimants: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to Oregon Claimants: Any person who, knowingly and with intent to defraud an insurance company or other person, submits an application or files a claim for insurance that contains any materially false information relating to an insurance company's acceptance of risk, or conceals for the purpose of misleading, information concerning any fact material to an insurance company's acceptance of risk, may be guilty of a fraudulent act, which is a crime.

Notice to Pennsylvania Claimants: 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.

Notice to Virginia Claimants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Notice to Claimants in all other states: Any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.