



Baggage and personal effects claim form and claimant's statement

Travel Guardian by UnitedHealthcare Global is underwritten by H&W Indemnity SPC for and on behalf of Global Solutions SP. Please complete this form to make a travel insurance claim.

Claimant's information

Account name and policy number

Name of claimant

Address

City

State

Postal code

Country

Email address

Home phone (include country code)

Cell phone (include country code)

Loss information

Date of loss

Please describe what occurred

Place of loss: Name and full address

Phone

Contact

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.

Copy of Police Report

Note: You must file a report with the appropriate authorities for damaged, lost or stolen property.

Car rental agreement

A copy of your claim with the common carrier which shows the results of your claim for damaged or lost baggage.

If your baggage was not in the possession of a common carrier at the time of loss, please provide a police report or documentation from the responsible party which includes the date of loss, description of the loss, and list of items lost/stolen.

Proof of ownership of the items lost or stolen

Note: Acceptable forms of proof of purchase include credit card statements, sales receipts or cancelled checks.

Other (please describe)

Contact preference: Email Regular mail

Description of lost/stolen/damaged items

Item(s)	Estimated value	Have you received reimbursement?	If so, from whom?	How much?
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
Total	\$			\$

Please use another page if you are claiming more items.

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 number	Contact	Phone (include country code)

AUTHORIZATION: By signing below, I agree that UnitedHealthcare Global can collect, use, and process sensitive personal data for individuals covered under this policy as needed in order to administer the policy and ensure that coverage is properly provided. I understand that this consent can be withdrawn at any time; however, if consent is withdrawn or refused, UnitedHealthcare Global may not be able to continue providing services including the payment of claims. I hereby authorize H&W Indemnity SPC for and on behalf of Global Solutions SP, or its representative, to inspect or secure copies of case history records or any other data necessary to determine eligibility of benefits. I also authorize H&W Indemnity SPC for and on behalf of Global Solutions SP, or its representative to release and share claim information including that which may be used in the identification and prevention of potential fraudulent activity to any insurance organization, fraud information clearinghouses, designated service providers and business associates assisting in the processing of this claim. A photostatic copy or facsimile of this authorization shall be deemed as effective and valid as the original. This authorization is valid for twelve (12) months from date of signature. **I HAVE REVIEWED AND ACKNOWLEDGE THE ATTACHED FRAUD WARNING.**

Signature of insured

Date

Mailing instructions

Send this form and any accompanying documentation to:

Attention: Co-Ordinated Benefit Plans, a subsidiary of One80 Intermediaries
On Behalf of H&W Indemnity SPC for and on behalf of Global Solutions SP.

P.O. Box 26222

Tampa, FL 33623

OR

Email to: TGGClaims@cbpinsure.com

Customer Care: **1-833-610-0736**

Consent to receive all communications electronically

Please be advised, our preferred method of communication with you is electronically by email. Use of email helps us provide better and faster service. Please provide your consent to this in the area below. We will keep this on file with your claim.

Expressed consent to receive all communications electronically:

I agree to receive all mailings and communications electronically

I have read and agree to the **terms and conditions** of the electronic delivery*

I accept Yes No

Please confirm the preferred email address:

Email address _____

*Click the terms and conditions above to review online, or download a copy by typing the below URL into your internet browser.

<http://policydocuments.tpaproducts.com/EDOD/consent.pdf>

Important Notice

Fraud Warning: Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

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 Kentucky 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 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.

Notice to Minnesota 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 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 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 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 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 West Virginia 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.

Please maintain a copy of this document for your records.