Trip interruption 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)		

Travel supplier/provider information

If your trip arrangements were made through a travel agent, please provide the agent's information, if not then provide the information as related to the cruise line, land operator or airline as applicable.

Company name	Address		
City	State	Postal code	Country
Contact	Phone (include country code)		
Date travel protection plan was purchased	Date of initial payment deposit		
Scheduled date of departure	Scheduled date of return		
If not included in package, how was air travel arranged?			

continued

Loss information

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

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 interruption

Date trip was interrupted

Reason for interruption

If interruption is due to medical reasons

Name of person having sickness or injury

Date of birth	Relationship to claimant
Date sickness or injury began	Date ended

Nature of sickness or injury (if injury, describe accident, including date and place)

Period of hospitalization (if applicable)

To be completed by the attending physician

Name of patient		Name of doctor		
Office address	City	State	Postal code	Country
Office phone		Office fax		
Patient date of birth	Date symptoms first appeared or accident occurred			
Date of first treatment	Was patient treated by someone else? ☐ Yes ☐ No			
If so, by whom?		When?		

Diagnosis

If patient is the traveler, did you prohibit patient's traveling by air or otherwise due to this injury/illness? ☐ Yes ☐ No

continued

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 protection 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 statement.

Physician name	Physician's signature
Taxpayer ID	Date completed

Authorization for release of medical information – To be completed by patient

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, laboratory reports, diagnosis, prognosis, x-rays, and any other data necessary to determine eligibility of benefits. I also authorize H&W Global Solutions Segregated Portfolio (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 support organization, fraud information clearinghouses, designated service providers and business associates assisting in the processing of this claim. A photo-static copy of 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.

Signature	Date

(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.

- ☐ Copies of cancelled checks or credit card statements that shows all payments made for the trip with an invoice from your travel provider showing the total cost paid for the trip
- ☐ Airline ticket stub/receipt
  Note: Copies of new airline tickets purchased due to interruption (if applicable) along with documentation of the cost incurred. Please forward the original airline tickets if applicable.
- ☐ Police Report (if applicable)
- ☐ Car rental agreement (if applicable)
- ☐ 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)

Please contact me by: ☐ Email ☐ Mail

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	Phone (include country code)

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AUTHORIZATION: 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

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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.

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