CSA TRAVELPROTECTION
A Europ Assistance Group Company

Dear Policyholder:

Please complete and sign the attached claim form. Additionally, the following items are needed in order to process your **Trip Cancellation** claim in the most efficient and expedient way possible.

What you should provide:

- A signed and completed "Patient Authorization Form." Regulations under HIPAA (Health Information Portability and Accountability Act) were enacted nationwide by doctors' offices, hospitals and other health care providers. As a result, we must request that the patient or their authorized legal representative sign and complete the enclosed form in its entirety. Authorized legal representatives must include a copy of their designation as such. **Failure to provide this documentation may result in a delay of your claim;**
- All original, unused, non-refundable tickets (including e-tickets). If they are not in your possession, please provide the contact information so we can retrieve them. If they are refundable, please return them to the supplier for refund processing and advise if there are penalties;
- Actual proof of payment for the trip, such as credit card statements or copies of front and back of cancelled checks. **Invoices will not be accepted as actual proof of payment**;
- Proof of refunds received, such as credit card statements or copies of front of checks;
- Proof of age for all parties making a claim, such as copies of driver's licenses or passports. If any parties are minors, please provide the names and addresses of their parents or legal guardians. If multiple parties are making a claim, please state their relationship to one another;
- All invoices and itineraries or a copy of the reservation confirmation;
- All carrier and supplier cancellation policies (schedule of penalties) that applied to your trip;
- Please note: if you are emailing your claim, our system does not accept files over 10MB in size.

What you should obtain and submit from the patient's physician:

- The completed "Physician's Statement" or copies of the medical records. A doctor's note is not sufficient as it may not provide all details needed for your claim.

EACH PARTY MAKING A CLAIM MUST SIGN THE COMPLETED CLAIM FORM.

PLEASE ENSURE THAT YOU HAVE NOTIFIED YOUR TRAVEL AGENT OR SUPPLIER OF YOUR CANCELLATION.

Written proof of loss must be sent to us within 90 days after the date the loss occurs. We will not reduce or deny a claim if it was not reasonably possible to give us written proof of loss within the time allowed. In any event, you must give us written proof of loss within twelve (12) months after the date the loss occurs unless you are medically or legally incapacitated.

Thank you. Should you have any questions, please call us at (800) 541-3522.

TRIP CANCELLATION, INTERRUPTION, MISSED CONNECTION, & TRAVEL DELAY CLAIM FORM

CSA TRAVELPROTECTION
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IMPORTANT: ALL PAGES OF THIS CLAIM FORM MUST BE COMPLETED IN FULL AND SIGNED. FAILURE TO DO SO MAY DELAY THE PROCESSING OF YOUR CLAIM.

SECTION 1: PERSONAL & TRAVEL INFORMATION

NAME OF INSURED		POLICY/REFERENCE #		SCHEDULED TRAVEL DATES
BOOKING/RESERVATION #	DATE OF BIRTH	HOME/CELL PHONE	BUSINESS PHONE	EMAIL ADDRESS
INSURED MAILING ADDRESS		CITY	STATE	ZIP CODE
CO-INSURED/TRAVELING COMPANION(S)	DATE OF BIRTH	HOME/CELL PHONE	BUSINESS PHONE	EMAIL ADDRESS
CO-INSURED/TRAVELING COMPANION(S) MAILING ADDRESS		CITY	STATE	ZIP CODE
TRAVEL AGENT/RENTAL COMPANY	TRAVEL AGENT'S NAME	TELEPHONE	EMAIL ADDRESS	
TRAVEL AGENT'S MAILING ADDRESS		CITY	STATE	ZIP CODE

SECTION 2: DETAILS OF LOSS

REASON FOR TRIP CANCELLATION, TRIP INTERRUPTION, OR TRAVEL DELAY		
DATE TRIP WAS CANCELLED, INTERRUPTED, OR DELAYED	NUMBER OF TRAVELERS	DESTINATION

SECTION 3: AMOUNTS CLAIMED

DESCRIPTION/NAME OF SUPPLIER	AMOUNT PAID	AMOUNT REFUNDED TO YOU	AMOUNT CLAIMED
NOTICE: IF YOU HAVE MORE ITEMS, PLEASE ATTACH A SEPARATE SHEET.		TOTAL AMOUNT CLAIMED:	

PLEASE COMPLETE OTHER SIDE

FRAUD WARNINGS AND DISCLOSURES

Arizona: 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.

Alaska, Minnesota, New Hampshire: 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.

Arkansas, Louisiana, New Mexico, Texas, West Virginia: 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to any insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may 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.

Maine, Virginia, Tennessee, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company 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.

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

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self insured program files a statement of claim or an application containing any false or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

District of Columbia: 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.

Oklahoma: 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.

Kentucky, Pennsylvania: 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.

Kansas: 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 may be guilty of insurance fraud as determined by a court of law.

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

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

New York: 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 violation.

Ohio: Any person who, with 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.

Oregon: Any person who knowingly and with intent to defraud, files a claim for benefits may be guilty of insurance fraud and may be subject to prosecution.

☐ By checking this box, I/we, the insured(s), agree that my/our electronic signature(s) shall be the legal equivalent of my/our manual signature(s) on the document. I/we, the insured(s), attest that all the statements in this document are true and complete to the best of my/our knowledge. I/we authorize CSA Travel Protection to contact me/us or anyone else involved in this matter, to verify whether or not this loss occurred. I/we further authorize CSA Travel Protection to release and share claim information including that which may be used in the identification and prevention of potential fraudulent activity to Generali U.S. Branch, Generali Assicurazioni Generali S.p.A. (U.S. Branch), Assicurazioni Generali – U.S. Branch, Generali U.S. Branch DBA The General Insurance Company of Trieste & Venice, The General Insurance Company of Trieste and Venice – U.S. Branch, Stonebridge Casualty Insurance Company, Transamerica Casualty Insurance Company, insurance support organizations, fraud information clearinghouses, designated service providers and business associates assisting in the processing of the claim.

INSURED'S SIGNATURE	PRINT NAME	DATE
ADDITIONAL INSURED SIGNATURE	PRINT NAME	DATE

SECTION 4: PHYSICIAN'S STATEMENT (TO BE COMPLETED BY PHYSICIAN ONLY)

PATIENT INFORMATION

Patient's Name	Date of Birth

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	If NO, primary care physicians name	Phone	Was the patient referred to you by the primary care physician? ☐ YES ☐ NO

PATIENT'S DIAGNOSIS

Diagnosis	ICD Code	On what date did the symptoms/injury first appear?	Did you perform an actual examination? ☐ YES ☐ NO	Date of initial examination:

Please list all dates of examination and treatment	Is this condition a complication of an underlying condition? If yes, please explain ☐ YES ☐ NO

If the patient is our insured traveler, on what date did he/she become medically unable to travel?	How long will the patient be disabled?	Did you advise that the trip should be cancelled or interrupted due to the patient's medical condition? If yes, what date? ☐ YES ☐ NO DATE_____

Please provide details explaining the patient's diagnosis. If you advised the patient that the trip should be cancelled or interrupted due to this medical condition, please explain the basis for your travel recommendation. If this is due to an injury, please give details of the injury.

Please provide details surrounding your prior treatment of this patient.

BY MY SIGNATURE AND STAMP BELOW, I HEREBY CERTIFY THAT THE ABOVE IS TRUE AND CORRECT.

Physician Signature	Print Name	Tax ID	Date

Patient Authorization Form

Name of Patient:_____ Date of Birth:_____
SS#:_____ Purpose of release: TRAVEL INSURANCE CLAIM

DOCTORS AND/OR MEDICAL FACILITIES AUTHORIZED TO RELEASE MY HEALTH INFORMATION:

Name	Address	Telephone	Fax	Dates Treated

You are authorized to release any health information that may have bearing on the request for benefits submitted in conjunction with the travel protection plan to: CSA Travel Protection and Insurance Services, its affiliates, underwriters, and any agent expressly acting on behalf of CSA Travel Protection and Insurance Services. Additionally, if you suspect and/or identify fraudulent activity, please release any and all information that will assist in the reporting and prevention of these fraudulent acts. Fraudulent activity should be reported to the underwriters, insurance support organizations, fraud information clearinghouses, and designated service providers.

Send to: CSA Travel Protection and Insurance Services
Attn: Claims Department, P.O. Box 939057, San Diego CA 92193-9057
FAX: 877-300-8670
Information to be released: Physician Dictation, Physical and/or Occupational Therapy Records, Office Notes, Lab Reports, Entire Record, Other: _____

I UNDERSTAND THE FOLLOWING:

- If applicable, HIV/AIDS, genetic testing, abuse, drugs/alcohol and/or mental health records will be included in the health information that is released.
- I may revoke this authorization to the health information management department in writing. My revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless revoked, this authorization will expire in six months.
- I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. Any disclosure of information carries with it the potential for any unauthorized re-disclosure and such unauthorized re-disclosed information may not be protected by federal confidentiality requirements.
- THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.
- My treatment, payment, or enrollment may not be conditioned on signing this authorization. If I refuse to sign this authorization, benefits may not be paid under the travel protection plan if additional health information is needed to determine my eligibility for benefits.

Signature of patient or authorized person Date:

Relationship/Reason patient is unable to sign