Safe Travels Claim Form and Insured Statement

Trip Cancellation/Interruption/Reunion

Please send completed form and supporting documents to:

- **Email:** GBGclaims@cbpinsure.com
- **Mail:** Co-ordinated Benefit Plans, LLC on Behalf of Global Benefits Group PO Box 2069 Fairhope AL 36533
- **Fax:** 866-616-0444

For claim status: U.S./Canada toll-free: +1-866-669-9004/ **Local:** +1-251-928-0939

A. INSURED INFORMATION	
Name (Last, First, MI):	
Date of Birth (MM/DD/YYYY):	National ID/Visa #:
Address:	
Postal Code:	Country:
Phone:	Email:
Policy #:	ID #:
Travel Destination:	Policy Purchase Date (MM/DD/YYYY):
Policy Effective Date (MM/DD/YYYY):	Policy Termination Date (MM/DD/YYYY):
B. TRAVEL SUPPLIER/AGENCY INFORMATION (if applicable)	
Company:	
Address:	
Postal Code:	Country:
Contact Name:	
Email:	Phone:
Date Travel Arrangements were made (MM/DD/YYYY):	
Date of Initial Payment Deposit (MM/DD/YYYY):	
Scheduled Date of Departure (MM/DD/YYYY):	Scheduled Date of Return (MM/DD/YYYY):
If not included in a package, how was air travel arranged?	
C. TRIP CANCELLATION/INTERRUPTION INFORMATION	
Cancellation Date/Notice/Interruption (MM/DD/YYYY):	Place:
If Cancellation/Interruption involves another party, please fill in the below:	
Name of party involved:	
Relationship to Insured:	
Reason for Cancellation/Interruption:	

D. LOSS INFORMATION

After completing this section, attach copies of all travel documents supporting penalties, added costs or nonrefundable charges incurred by you due to cancellation, delay or disruption. If needed, attach another sheet with information.

Company Name (Airline/Hotel)	Amount Paid	Amount of Loss (non-refundable)	Have you received reimbursement?	If Yes, from whom?	If Yes, how much?
			☐ Yes ☐ No		

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Loss Information (continued)

Company Name (Airline/Hotel)	Amount Paid	Amount of Loss (non-refundable)	Have you received reimbursement?	If Yes, from whom?	If Yes, how much?
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		

If you are claiming due to the Insured's medical reasons, fill out Section E. If you are claiming due to the medical reasons or death of a family member or traveling companion, fill out Section F.

E. SUPPLEMENTAL INFORMATION: CLAIM DUE TO INSURED'S MEDICAL REASONS

E-1: Patient Authorization for Release of Medical Information (To be filled out by Insured)

In order to process a claim for benefits, I authorize any physician, hospital, or other Medical Provider to release Co-ordinated Benefit Plans, LLC , Trawick International, or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed two and one-half years from the date signed. I understand I have a right to receive a copy of this authorization.

Signature:	Date:
Date Sickness/Injury began (MM/DD/YYYY):	Date ended (MM/DD/YYYY):

Nature of Sickness/Injury (If Injury, describe accident and provide date and place):

If applicable, period of hospitalization, from: _____, to: _____.

E-2: Medical Information (To be filled out by Attending Physician)

Doctor/Facility/Provider Name:	
Address:	
Postal Code:	Country:
Phone:	Email:
Fax:	Provider Taxpayer ID # (if applicable):
Patient Name:	Age:
Date Symptoms first appeared/accident occurred (MM/DD/YYYY):	
Date of first treatment (MM/DD/YYYY):	

Was patient treated by someone else? ☐ Yes ☐ No	If yes, by whom?	If yes, when?

Did you prohibit the patient's travel by air/otherwise due to this illness/injury? ☐ Yes ☐ No

Was the patient traveling to receive medical treatment? ☐ Yes ☐ No ☐ I do not know

Authorization: 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 statements.

Physician's signature:	Date:

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F. SUPPLEMENTAL INFORMATION: CLAIM DUE TO FAMILY MEMBER/TRAVEL COMPANION	
Name of person having sickness/injury:	Date of Birth:
Relationship to member:	
Date Sickness/Injury began:	Date Sickness/Injury ended:
Nature of Sickness/Injury (If Injury, describe accident and provide date and place):	
If applicable, period of hospitalization, from: _____, to: _____.	
If applicable, his/her date of death (MM/DD/YYYY):	

G. 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. Please keep copies of any items submitted with this claim.

- ☐ Airline Ticket Stub/Receipt
- ☐ Cancellation/interruption/reunion statement from hotel, airline or airport. Note: Any cancellation/delay of flight must be documented by the airline.
- ☐ Car Rental Agreement
- ☐ Check/Credit Card Statement with an invoice from your Travel Provider/Agency showing the date of your deposit.
- ☐ Death Certificate
- ☐ Police Report
- ☐ Reimbursement statements issued by an airline, airport, rental car agency, travel agent, hotel or other similar establishment or any other insurance company providing reimbursement to you for the loss
- ☐ Other:

H. REIMBURSEMENT METHOD

Please reimburse: ☐ Primary Insured ☐ Provider (Payment by check) ☐ Family Member (Payment by check)

REIMBURSEMENT METHOD: Request preferred method of reimbursement below.

- ☐ Check to Insured's Address, as listed in INSURED INFORMATION section.
- ☐ Check to other Mailing Address:
- ☐ Send by Electronic Direct Deposit (U.S. banks only) or Wire Transfer (non-U.S. banks)
  - Bank Name:
  - Name on Account:
  - Account #/IBAN:
  - Routing #/ABA # (for Electronic Direct Deposit):
  - SWIFT code (for Wire Transfer):
  - Bank Address (for Wire Transfer):

I. FRAUD NOTICE/AUTHORIZATION

I-1: Fraud Notice

General: 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.
Alaska: 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.
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.
Arkansas, Louisiana, Maryland, 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 fines and confinement in prison.
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.

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Fraud Notice (continued)

Colorado: 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 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 member for the purpose of defrauding or attempting to defraud the policyholder or member 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.
Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.
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, incomplete or misleading information is guilty of a felony.
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.
Florida: 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.
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.
Kentucky: 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.
Maine: 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.
Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another 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, and subjects the person to criminal and civil penalties.
Minnesota; A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil 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 Mexico: 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.
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 such 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.
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.
Oregon: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.
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.
Tennessee, Virginia, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
Texas: 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.

I-2: Authorization

I AUTHORIZE any insurance company, physician, hospital, and other health care providers, any travel organization or agency, airline carrier, rental agency, hotel, motel, or similar entity providing lodging on a rental/lease basis or any other person who may have knowledge regarding this claim, to release any information requested regarding this claim and the loss reported.

I UNDERSTAND the information obtained by use of the authorization, will be used by Co-ordinated Benefit Plans, LLC/Trawick International to determine eligibility for benefits under this plan. Any information obtained will not be released by Co-ordinated Benefit Plans, LLC/Trawick International to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I further authorize.

I KNOW that I may request to receive a copy of the Authorization. I AGREE that a photographic copy of this authorization is as valid as the original. I AGREE that this Authorization shall be valid for two and one half years from the date shown below. I UNDERSTAND that it is illegal to knowingly file a false or fraudulent claim or to knowingly help someone else file one. I have read and understand the Fraud Notices.

Insured Person

Name:

Signature:

Date:

Please send completed form and supporting documents to:

- **Email:** GBGclaims@cbpinsure.com
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