Safe Travels Claim Form

To help us process your claim quickly, please follow these guidelines:

1. Complete a separate claim form for each person and each incident.

2. If you are submitting a claim for a medical incident: Check here □ and fill in Sections A, B C, & G

3. If you are submitting a claim for a non-medical incident: Check here □

Non-medical incidents include

- Trip Cancellation/Delay/Interruption fill in- Sections A, B, D & G
- Emergency Reunion fill in- Sections A, B, D & G
- Return of Minor Children/Traveling Companion fill in- Sections A, B, D & G
- Lost Baggage or Enhanced Baggage Benefit fill in- Sections A, B, E & G

4. If you would like to DESIGNATE a personal representative for us to talk to about your claim, please fill in Section F.

5. Please send this fully completed form to GBG Administrative Services with **ALL** original bills and requested documents relating to the claim in section G. All submissions MUST be received by GBG within 90 DAYS of the date of the loss or commencement of treatment.

FRAUD NOTICES:

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.

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 Hampshire: 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 section 638:20.
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, 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.
Payment of loss under this policy shall only be made in full compliance with all United States of America economic or trade sanction laws or regulations, including, but not limited to sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC").

A. AUTHORIZATION to RELEASE Information

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 Trawick International/GBG Claims to determine eligibility for benefits under this plan. Any information obtained will not be released by Trawick International/GBG Claims 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 fully understand the Fraud Notices.

Member/Patient Signature: ____________________________________ Date: ______________

Parent Signature (if Member/Patient is a minor) ______________________________ Date: ______________

B. Insured Information

Insured Name: (Last, First, MI):			Policy Number: Member Number: Date of Birth (mm/dd/yyyy): ______/______/______	
Home Country Address:		City:	State/Country:	Zip:
Phone Number:	Alternate Number:		E-mail Address:	
Correspondence Address: - place you want us to contact you via mail				
Your Home Country: (as declared on the application)		Your Destination: Arrival Date ______/______/______		

GBG ADMINISTRATIVE SERVICES

Effective Date _________/________/__________ Termination Date: _________/________/__________	Purpose of Trip: □ Holiday □ Business □ Medical □ Other (please specify): ______________________________
FOR EU CITIZENS ONLY:	
Was an EHC (European Health Card) taken on this trip? □ Yes □ No	Was the EHC card presented to the Hospital or Physician? □ Yes □ No (if no please explain)

C. Hospital & Medical Expenses (includes prescriptions, xrays, and doctor visits etc.)

Was the Assistance Company – Contacted: □ Yes □ No (If yes please give your file number ___________________________)

Is the claim the result of an Accident or Injury?: □ Yes □ No (if yes, please describe accident in detail and include the place/time where the injury occured):

Was the Accident or Injury the result of playing a sport or due to a hazardous activity? □ Yes □ No (if yes, please describe)

Is the claim the result of an Illness?: □ Yes □ No (if yes, please describe symptoms.)

Date Accident/Illness Started:	Date first treated for this Accident/Illness:	Name of Physician/Facility first consulted:

Address of Treating Physician/Facility:	Physician/Facility Phone Number:

Have you ever been treated for this illness/accident in the past?: □ Yes □ No (if yes, indicate the date first treated and treatment recommended):

List prescription medications you have been prescribed for your injury or Illness:

Is this a claim due to an unexpected recurrence of a pre existing condition ? □ Yes □ No (if yes, list name of physician currently treating this condition):

Name, Address and Phone Number of family physician/medical facility where the pre existing condition was first treated:

If prior treatment was given in hospital, as an inpatient please provide Name, Address and Phone Number of Facility Admitted to:

Admit Date: ________/_______/_________ Discharge Date: ________/_______/_________

List any pre existing conditions and prescription medications you took **prior** to your effective date. Include date illness started, medication dosage and name of prescribing doctor & Include herbal medications and vitamins:
____
____
____
____

Did any physician prohibit you from traveling by air or otherwise due to this injury/illness? □ Yes □ No

Were you traveling to receive medical treatment? □ Yes □ No (if yes, when did the you first learn of the alternative treatment and who recommended the treatment):

Are you pregnant: □ Yes □ No (if yes, indicate how many weeks):

Do you have Other Medical Insurance for this claim? □ Yes □ No
If yes, please provide the insurance carrier details including name, address and policy number:

D. Cancellation , Interruption, Delay, Return of Minor/Traveling Companion/Emergency Reunion

Date Travel Arrangements Made: ________/_______/_________ Date of Final Payment/Deposit: ________/_______/_________

Scheduled Date of Departure: _______/______/_________	Scheduled Date of Return: ________/_______/________
Date Trip Cancelled, Interrupted or Delayed: _____/_____/________	Destination or Place of Interruption or Delay:

Was the trip interrupted due to your own heath condition? □ Yes □ No (If yes, please provide information about the condition, including the date of diagnosis and treating physician.) Please provide documentation from your physician.

If Cancellation/Interruption/Delay involves another Covered Event, describe reason for Cancellation/Interruption and provide documentation:

Were additional expenses incurred?: □ Yes □ No (If yes, please provide details below and send all invoices/receipts with this claim form):

What amounts were refunded by the carrier, tour operator or other third party(including other insurance companies)? Attach copies of original receipts showing carrier, tour operator payment and destination: (If you **did not** get a refund please attach documentation to show that none was due.)

Amount	**Refunded by**	**Date**

EMERGENCY REUNION INFORMATION: (attach receipts for airfare, lodging and meals)

Travel Dates: From ________/_______/_________ to ________/_______/_________

Destination: ____

Date of Evacuation of the Insured Person: ________/_______/_________

Name of Person Evacuated: ____

Company Authorization Date: ________/_______/_________ Authorization Number: _________________________

E. Baggage/Personal Effects

Date of Loss or Damage: _________/________/__________

Time:

Baggage Claim Check Numbers:

Please provide a detailed description of how the loss/damage/theft occurred, including the location:

Please confirm when the loss/damage was reported and to which authority (e.g., police/airline/tour operator/hotel, etc.), including complete address and reference:

Reported to:	Item Lost/Damaged	Amount Paid For Item	Amount of Loss (nonrefundable)	Have you received reimbursement? (If yes give date.)	Who reimbursed you?	How much was reimbursed?
		$	$			$
		$	$			$
		$	$			$
		$	$			$
		$	$			$
		$	$			$
		$	$			$
		$	$			$
		$	$			$

		$	$			$

F: DESIGNATION OF A PERSONAL REPRESENTATIVE (OPTIONAL)

YOUR RIGHTS UNDER FEDERAL LAW: You have the right to authorize that the confidential information held by GBG Administrative Services and/or Trawick International be released to and/or received by persons or organizations you identify as indicated below with your signature. You are entitled, upon request, to receive a copy of this signed form.

I hereby authorize the request and release of my confidential information held to my personal representative. By appointing the person named below as my personal representative, I understand that I am authorizing to give this person access to my confidential information and medical records, the right to talk to about my medical care and the right to make decisions that will bind me. I agree that a photocopy, e-mailed copy or facsimile (FAX) copy of the authorization shall be accepted and as valid as the original.
This "**AUTHORIZATION TO APPOINT A PERSONAL REPRESENTATIVE**" is subject to revocation at any time except to the extent that action has been taken in reliance hereon and, if not earlier revoked in writing, it shall remain valid for two (2) years from date of signature.

Name (Last, First, MI):

Relationship: **Date of Birth:**

Current Address:

City:

Country:

Email Address: **Phone Number:**

Member/Patient Signature: ____Date: ________________

Personal Representative Signature: ____Date: ________________

G: DOCUMENTATION REQUIREMENTS

Depending upon the circumstance involved in the loss, one or more of the following items will 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.***

____ Medical Bills showing diagnosis and Credit Card/Cash Receipts for payment to the provider

____ Airline Ticket Stub/Receipt

____ Copies of cancelled checks or credit card statements within an invoice from your Travel Provider/Tour Operator showing the dates of your deposit, payments or purchase.

____ Police Report

____Statement from Hotel/Motel, Airline Carrier or Airport Facility which concerns: Cancellation/Interruption/Delay/Reunion.

(***Note:*** *Any cancellation or delay of flight must be documented by the airline.)*

____ 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. Include documentation that shows refund amounts or confirmation that no refund is due.

____ Baggage Claim Receipt and Passenger Irregularity Report, Receipts for loss or theft of luggage

____ Original Death Certificate

____ Copy of Obituary noting relationship to the Insured

____ Other (please describe):____

Send this form and any accompanying documentation to:

GBG Administrative Services
26741 Portola Pkwy Ste. 1E #527
Foothill Ranch, CA 92610
For claim status call 877-916-7920 Local: 949-916-7941
Claims status – mailto:info@gbgclaims.com