



4600 Witmer Industrial Estates, Suite 6
 Niagara Falls, NY 14305
 Telephone: 888-584-6171
 Fax: 877-367-2496

**TRIP CANCELLATION
 OR TRIP INTERRUPTION
 MEDICAL CLAIM FORM**

Please Note: *Benefits under any coverage will not be paid for expenses reimbursed or services provided by any other source. Benefits cannot be duplicated under this Protection Plan.*

PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF THE OCCURRENCE

Part I GENERAL INFORMATION

Claimant's Name (Last, First)		Policy No.		
Full Address				
Home Phone No.		Business Phone No.		
Full names of all persons claiming	Ages	Relationship to patient (if applicable)	Policy No.	
1) _____	_____	_____	_____	
2) _____	_____	_____	_____	
3) _____	_____	_____	_____	
4) _____	_____	_____	_____	
Name of Tour Operator (e.g. Cruise Line, Airline, etc)				
Travel Agency's Name		Travel Agent's Name	Telephone No.	
Travel Agency's Full Address				
Date Initial Deposit Paid for Trip <small>(MM / DD / YY)</small>	Date of Final Payment for Trip <small>(MM / DD / YY)</small>	Departure Date <small>(MM / DD / YY)</small>	Scheduled Return Date <small>(MM / DD / YY)</small>	Actual Return Date <small>(MM / DD / YY)</small>
Departure City		Destination (City, Country)		

Part II EXPLANATION OF LOSS

Reason for cancellation/interruption			
Date trip was cancelled/interrupted <small>(MM / DD / YY)</small>	Total Amount of Claim (in US \$)	Tour Cost Per Person (in US \$)	Cruise Cost Per Person (in US \$)
Air Fare Per Person (in US \$) <small>(MM / DD / YY)</small>	Did you receive a refund from the Travel Agent/Tour Operator after cancellation? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Please Indicate the Amount (in US \$)
Please Indicate Any Additional Expenses Incurred due to the Trip Interruption (e.g. accommodation, transportation, meals)			
Type of Expense	Date incurred (MM / DD / YY)	Amount	
1) _____	_____	_____	
2) _____	_____	_____	
3) _____	_____	_____	

Please enclose the receipts for the above claimed expenses

IMPORTANT - CLAIM CANNOT BE PROCESSED IF THIS FORM IS INCOMPLETE, PLEASE COMPLETE ALL APPLICABLE AREAS

Part III MEDICAL INFORMATION		
Patient's Name	Nature of injury or sickness	Date symptoms first noticed <i>(MM / DD / YY)</i>
For Injury, when, how and where did accident occur?		Date of first consultation <i>(MM / DD / YY)</i>
For Sickness, describe onset, diagnosis, and treatment		Date of first consultation <i>(MM / DD / YY)</i>
If hospitalized please indicate the name and address of Hospital	Dates of confinement From: <i>(MM / DD / YY)</i>	To: <i>(MM / DD / YY)</i>
Name of Family Physician	Telephone No.	Fax No.

Part IV OTHER COVERAGE		
Did you purchase any portion of your trip on a Credit Card? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, name and type of Credit Card (e.g. Visa Gold card)	
Do you have any other Insurance Coverage/Plans? (e.g. Travel, Credit Cards, etc) <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your loss been reported to any other Insurance Company? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, which Company?
1) Name of Insurance Company	Policy No.	Telephone No.
Address of Insurance Company		
2) Name of Insurance Company	Policy No.	Telephone No.
Address of Insurance Company		
3) Name of Insurance Company	Policy No.	Telephone No.
Address of Insurance Company		

I DECLARE THAT THE ABOVE INFORMATION IS TRUE, COMPLETE AND CORRECT.
I/We authorize any other insurance plan, under which I/We have coverage, to disclose information as may be necessary or to make payment in respect of my/our claim to Old Republic Insurance Company directly. I/We also authorize Old Republic Insurance Company to disclose to any other Plan, under which I/We have coverage, any and all information as may be necessary with respect to my/our claim.

Signature of Insured/Claimant

Date *(MM / DD / YY)*

Signature of Insured/Claimant

Date *(MM / DD / YY)*

Part V**TO BE COMPLETED BY INSURED**

Patient's Name _____ Patient's Date of Birth (MM/DD/YY) ____ | ____ | ____
 Insured's Name _____ Insured's relationship to Patient _____
 Policy Policy No. _____ Policy purchase date (MM/DD/YY) ____ | ____ | ____
 Scheduled departure date (MM/DD/YY) ____ | ____ | ____ Scheduled return date (MM/DD/YY) ____ | ____ | ____

Part VI ATTENDING PHYSICIAN'S STATEMENT - TO BE COMPLETED BY THE PHYSICIAN

1. Diagnosis - Nature of Injury or Sickness causing Cancellation/Interruption (*Please Be Specific*)
 - a) Primary Diagnosis _____
 - b) Secondary Diagnosis _____
2. a) When did symptoms first appear or injury occur? (MM/DD/YY) ____ | ____ | ____
 b) When did Patient first consult you? (MM/DD/YY) ____ | ____ | ____
 c) If Patient was referred **from** another physician, name of other physician. Tel No. (____) _____
 d) If Patient was referred **to** another physician, name of other physician. Tel No. (____) _____
 e) Names & Contact Numbers of all other physicians involved. _____
3. If condition causing Cancellation/Interruption is of a long-standing nature, was the Patient medically fit to travel on the Policy Purchase Date indicated above?
 Yes No If no, please explain: _____
4. Dates of all medical visits as it relates to the condition causing Cancellation/Interruption:

Date of Consultation (MM/DD/YY)	Describe the Condition/Treatment	Medication Prescribed/Changed
a) ____ ____ ____	_____	_____
b) ____ ____ ____	_____	_____
c) ____ ____ ____	_____	_____
5. a) Has the Patient been hospitalized for this condition or related condition(s) in the past 12 months? Yes No
 b) If Yes, date of admittance: (MM/DD/YY) ____ | ____ | ____ Date of discharge: (MM/DD/YY) ____ | ____ | ____
6. From what date did this condition prevent the Patient from traveling? (MM/DD/YY) ____ | ____ | ____
7. If the Patient is not the Insured, from what date was travel precluded for the Insured due to the Patient's condition? (MM/DD/YY) ____ | ____ | ____
8. On what date was this condition stable and controlled to permit travel? (MM/DD/YY) (MM/DD/YY) ____ | ____ | ____
9. a) Did you advise the Patient/Insured to cancel travel plans prior to departure or return home early as a result of this condition? Yes No
 b) If Yes, on what date? (MM/DD/YY) ____ | ____ | ____ Please explain: _____
 c) If No, on what date was it reasonable for the Patient/Insured to Cancel/Interrupt their travel plans? (MM/DD/YY) ____/____/____
10. If condition was related to pregnancy, when was the pregnancy first diagnosed? (MM/DD/YY) ____ | ____ | ____
 Expected Delivery Date? (MM/DD/YY) ____ | ____ | ____
11. Was this injury or sickness the sole cause of the Patient's disability leading to Cancellation/Interruption? Yes No
 If No, please explain: _____

Physician's Remarks: _____

Signature of Physician _____ Date Completed: ____ | ____ | ____
 Name of Physician: _____ Telephone No. (____) _____
 Address of Physician: _____ Fax No. (____) _____
 Taxpayer Identification No. _____

Part VII PATIENT CONSENT TO DISCLOSE HEALTH INFORMATION

Patient's full name at time of treatment: _____

Date of birth: (MM/DD/YY) ____ | ____ | ____ Social Security Number: _____

Address: _____

Purpose of release: **ADJUDICATION OF TRAVEL INSURANCE CLAIM**

Effective Date of Insurance Coverage: (MM/DD/YY) ____ | ____ | ____

Medical Facilities: (List all doctors consulted for this condition and hospitals where confined)

<i>Name</i>	<i>Address</i>	<i>Telephone No.</i>	<i>Fax No.</i>	<i>Dates</i>
_____	_____	_____	_____	____ ____ ____
_____	_____	_____	_____	____ ____ ____
_____	_____	_____	_____	____ ____ ____
_____	_____	_____	_____	____ ____ ____
_____	_____	_____	_____	____ ____ ____

You are authorized to give **Old Republic Insurance Company** and its affiliates, reinsurers, agents, consumer reporting agency, or independent claims administrator acting on behalf of Old Republic Insurance Company, any information concerning insurance coverage, medical care, advice, treatment or supplies, or any other information that may have bearing on the request for benefits submitted in conjunction with the travel insurance policy.

Information to be released:

All medical records of the Patient from three months before the Effective Date of Insurance Coverage as shown above through the date of this consent as shown below. "Medical records" includes, without limitation, diagnosis list, medication list, physician dictation, office notes, physical therapy records, occupational therapy records, pathology reports, cytology reports and the results of all laboratory tests.

**Send to: Old Republic Insurance Company
Travel Claims Department
4600 Witmer Industrial Estates,
Suite 6, Niagara Falls, NY 14305.
Telephone: 1-888-584-6171 Fax: 1-877- 367-2496**

By signing below, I understand that:

1. The information in my health record may include information relating to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I have the right to revoke this consent at any time by providing my written revocation to the facility where my records are kept.
3. A revocation will not apply to information that has already been released in response to this consent.
4. A revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. Unless otherwise revoked, this consent will expire in six months.
6. Consenting to the disclosure of this health information is voluntary. I can refuse to sign this consent.
7. Any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of patient or authorized person: _____ Date: (MM/DD/YY) ____ | ____ | ____

Relationship/Reason patient is unable to sign: _____

CLAIM FORM FRAUD REQUIREMENTS

All States Other Than Those Listed:

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.

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.

California

For your protection California law requires the following to appear on this form: 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.

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 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 Affairs.

Delaware

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

District of Columbia

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 application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho

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

Indiana

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

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.

Louisiana

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.

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.

Maryland

Any person who, with intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire

Any person who, with a purpose of 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.

New Jersey

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

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

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.

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

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

I CERTIFY THAT I HAVE READ THE FRAUD STATEMENT THAT APPLIES TO MY STATE OF RESIDENCE.

Signature _____

Date _____

(MM / DD / YY)