OLD REPUBLIC INSURANCE COMPANY

Travelex Claims Department
4600 Witmer Industrial Estates, Suite 6
Niagara Falls, NY 14305
Telephone: 888-322-6776
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)*	Conf. No.	Date of Birth

Full Address

Home Phone No.	Business Phone No.

Full name of all persons claiming	Ages	Relationship to patient *(if applicable)*	Policy No.
1)			
2)			
3)			
4)			

Name or 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 *(MM / DD / YY)*	Date of Final Payment for Trip *(MM / DD / YY)*	Departure Date *(MM / DD / YY)*	Scheduled Return Date *(MM / DD / YY)*	Actual Return Date *(MM / DD / YY)*

Departure City	Destination *(City, Country)*

Part II — *EXPLANATION OF LOSS*

Reason for cancellation/interruption

Date trip was cancelled/interrupted *(MM / DD / YY)*	Total Amount of Claim (in US $)	Tour Cost Per Person (in US $)	Cruise Cost Per Person (in US $)

Air Fare Per Person (in US $)	Did you receive a refund from the Travel Agent/Tour Operator after cancellation? ❑ Yes ❑ No	If Yes, Please Indicate the Amount (in US $)

For Trip Delay, please Indicate Any Additional Expenses Incurred (e.g. accommodation, transportation, meals)

Type of Expense	Date incurred *(MM / DD / YY)*	Amount
1)		
2)		
3)		

Please enclose the original 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 *(MM / DD / YY)*
For Injury, when, how and where did the accident occur?		Date of first consultation *(MM / DD / YY)*
For Sickness, describe onset, diagnosis and treatment		Date of first consultation *(MM / DD / YY)*
If hospitalized please indicate the name and address of Hospital	Date of confinement From: *(MM / DD / YY)*	To: *(MM / DD / YY)*
Name of Family Physician	Telephone No.	Fax No.

Part IV	**OTHER COVERAGE**	
Did you purchase any portion of your trip on a Credit Card? ❑ Yes ❑ 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) ❑ Yes ❑ No	Has your loss been reported to any other Insurance Company? ❑ Yes ❑ 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)* _____ I _____ I _____

Insured's Name _____ Insured's relationship to Patient _____

Conf. No. _____ Policy purchase date *(MM/DD/YY)* _____ I _____ I _____

Scheduled departure date *(MM/DD/YY)* _____ I _____ I _____ Scheduled return date *(MM/DD/YY)* _____ I _____ I

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)* _____ I _____ I _____
   b) When did Patient first consult you? *(MM/DD/YY)* _____ I _____ I _____
   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 is of a long-standing nature, was medical approval given for the trip?
   ❑ Yes ❑ No If yes, please provide date: *MM/DD/YY)* _____ I _____ I _____
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)	_____ I _____ I _____	_____	_____
b)	_____ I _____ I _____	_____	_____
c)	_____ I _____ I _____	_____	_____

5. Has the Patient been hospitalized for this condition or related condition(s) in the past 12 months? ❑ Yes ❑ No
   If Yes, date of admittance: *(MM/DD/YY)*_____ I _____ I _____ Date of discharge: *(MM/DD/YY)* _____ I _____ I _____
6. a) From what date did this condition prevent the Patient from traveling? *(MM/DD/YY)* _____ I _____ I _____
   b) On what date was this condition stable and controlled to permit travel? *(MM/DD/YY)* _____ I _____ I _____
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)* _____ I _____ I _____
8. 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
   If Yes, on what date? *(MM/DD/YY)* _____ I _____ I _____ Please explain: _____
   If No, on what date was it reasonable for the Patient/Insured to Cancel/Interrupt their travel plans? *(MM/DD/YY)* _____/_____/_____
9. If condition was related to pregnancy, when was the pregnancy first diagnosed? *(MM/DD/YY)* _____ I _____ I _____
   Expected Delivery Date? *(MM/DD/YY)* _____ I _____ I _____
10. 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: _____ I _____ I _____

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) _____ | _____ | _____

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)

Name	*Address*	*Telephone No.*	*Fax No.*	*Dates*
_____	_____	_____	_____	_____ | _____ | _____
_____	_____	_____	_____	_____ | _____ | _____
_____	_____	_____	_____	_____ | _____ | _____

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 for up to 180 days before the Effective Date of Insurance Coverage as shown above through the date of this consent as shown below as applicable based on the patients age as outlined the policy. "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: 1-888-322-6776 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.

I authorize Old Republic Insurance Company to disclose my health or claim information to any relevant source (e.g. airline, tour operator, travel suppliers, etc.) for the purpose of obtaining recoveries or any outstanding refunds after my insurance claim has been settled. I hereby assign to Old Republic Insurance Company any benefits or recoveries obtained from these sources for losses covered under this policy. I direct these sources to forward reimbursement to Old Republic Insurance Company with regard to these losses.

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

Relationship/Reason patient is unable to sign: _____

CLAIM FORM FRAUD REQUIREMENTS

MANDATORY: Please Read and Sign Below

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 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 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.

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 fixes 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. IF MY STATE OF RESIDENCE IS NOT LISTED, I CERTIFY THAT I HAVE READ THE "ALL OTHER STATES OTHER THAN THOSE LISTED"

Signature _____ **Date** _____ ***(MM / DD / YY)***