Chubb Educational Travel

CHUBB

Claim Forms

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Chubb Educational Travel Claim Form

Instructions

When reporting the claim please provide your name, Policy Number, Program ID number, type of claim, and preferred contact information. Once you have completely filled out the appropriate sections of the claim form, submit it to *Administrative Concepts, Inc.* (contact information below). In addition to the claim form, you may be required to provide other specific information. In order to expedite your claim, please provide the applicable documentation based on the coverage(s) you are claiming.

Quick Reference Guide

☐ **Trip Cancellation/Interruption/Delay** *(complete Part A)*

Paid receipts for all of the following items

- The amount of the non-refundable amounts paid for the trip:
  - Any cancellation charges
  - Any prepaid, unused, non-refundable airfare and sea or land accommodations
  - Any other reasonable additional trip expenses for travel, lodging, or scheduled events that are prepaid, unused, and non-refundable
  - The cost of a one-way economy air and/or ground transportation ticket
- Proof of covered reason for claim
- If applicable, include Attending Physician Statement for the individual with medical condition and complete Part C: Medical Expense

☐ **Lost Baggage** *(complete Part B)*

- Must file a formal claim with the transportation provider and provide us with copies of all claim forms and proof that the transportation provider has paid its normal reimbursement for lost, stolen, or damaged luggage

☐ **Baggage Delay** *(complete Part B)*

- Documentation of delay or misdirection of baggage by common carrier
- Proof of purchase (receipts, credit card statements, etc.)

☐ **Medical Expense** *(complete Part C)*

- An itemized bill from the treating physician
- Prescription – receipt showing claimant's name and the cost of the medication
- Attending Physician's Statement

☐ **Repatriation of Remains** *(complete Part C)*

- Expense for embalming or cremation
- The least costly coffin or receptacle adequate for transporting the remains
- Cost to transport the body from place of loss to his/her home country

☐ **Accidental Death & Dismemberment** *(refer to AD&D Claim Form)*

Please Email your completed claim form with legible documentation to:

Administrative Concepts, Inc.
994 Old Eagle Road Suite 1005 • Wayne, PA 19087-1802
Email: aciclaims@visit-aci.com

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All Sections need to be completed for claims submissions.
Complete the Part portion specific to benefit being claimed. If you have a covered medical reason you must complete Part C and include an Attending Physician's Statement.

I. General Information

Plan Purchased _____ Policy ID Number _____

Program ID Number _____

Trip Departure Date _____ Trip Return Date_____

Reason for Claim:

_____

_____

_____

_____

II. Insured Information

Primary Insured Name_____

Primary Insured Date of Birth _____

Parent or Guardian (if under 18) _____

Home Phone # _____ Work Phone # _____

Please provide telephone numbers, with country and city codes.

Email Address_____

Preferred Contact Method_____

Other Coverage Information

Do you have any other insurance? (i.e. health or homeowners insurance) ☐ Yes ☐ No

If yes, please provide source of insurance _____

Are claim expenses recoverable from another source? ☐ Yes ☐ No

If yes, please provide details and amounts:

_____

_____

_____

_____

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III. Payment Information (funds will be issued in U.S. currency)

Payment to Insured, Guardian or Beneficiary

☐ Your home address as listed above ☐ Direct deposit to your bank account

Name on Account _____

Bank Name _____

Bank Address _____

Account Number _____ Account Type ☐ Checking ☐ Savings

Bank Routing # or Swift Code _____

IBAN _____

IV. Claim Information

Part A. Trip Cancellation / Trip Interruption / Trip Delay

☐ Trip Cancellation ☐ Trip Interruption ☐ Trip Delay

Date and time of incident _____

Date Trip Cancelled/Interrupted/Delayed _____

Reason for Claim:

_____

_____

_____

_____

Are all insureds listed on policy impacted? ☐ Yes ☐ No

If no, provide list of insureds impacted.

_____

_____

Was the cancellation/interruption a result of your own injury/sickness? ☐ Yes ☐ No

If yes, please fill out Part C.

Was the cancellation/interruption a result of injury/sickness to a relative or person defined in the Policy? ☐ Yes ☐ No

If yes, please fill out the below and Part C.

Name _____ Relationship to you _____

Address _____

If claiming Trip Delay, how long was your delay? _____

Please provide all documentation supporting the reason for your Trip Cancellation/Interruption/Delay.

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Part A. Trip Cancellation / Trip Interruption / Trip Delay *(continued)*

Chart of Claimed Expenses (Please provide receipts supporting the below expenses)

Type of Expense	Name of Individual Associated with Expense	Date of Expense	Receipts Attached	Expense Amount
			Total Sum Claimed	

Part B. Lost Baggage/Baggage Delay

☐ Lost Baggage ☐ Baggage Delay

Date of loss / damage / theft _____

Country where loss / damage / theft occurred _____

Details of loss / damage / theft _____

To whom was loss / damage / theft reported _____

If article(s) lost/stolen, what steps were taken regarding recovery of article(s)? (Provide any written evidence)

_____

_____

_____

_____

If article(s) damaged, please supply estimates for cost of repairs or a letter from a reputable dealer confirming irreparably damaged. (Supply receipts: if not available, please supply replacement estimates/invoices)

_____

_____

_____

_____

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Part B. Lost Baggage/Baggage Delay *(continued)*

Is any property lost/damaged/stolen insured by another company? ☐ Yes ☐ No

If yes, please supply name, address, telephone number, and policy number.

Please supply name, address telephone number, and policy numbers of homeowners/household contents insurers.

Have you ever had any previous claims on this type of insurance? ☐ Yes ☐ No

If yes, please supply details with relevant dates.

Particulars of Claim

Full Description of Each Item of Property Lost, Damaged, or Stolen	State to Whom Property Belonged	Date of Purchase	Original Purchase Price	Receipts/ Replacement Estimates Attached
			Total Sum Claimed	

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Part C. Medical Expense & Repatriation of Remains

Patient's Name _____ Date of Illness (first symptom) or injury _____

Relationship to the Primary Insured _____

Diagnosis or nature of illness or injury _____

If injury – please describe _____

_____

Date first consulted for this condition _____

Hospital Confinement Dates From _____ To _____

Disability Dates **Total:** From _____ To _____ **Partial:** From _____ To _____

Place of Service _____

Treating Doctor(s) _____

Treating Doctor City, State _____

Primary Care Physician (PCP) _____

PCP City, State _____ PCP Phone # _____

Include copy of Attending Physician Statement with documentation.

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V. Declaration

I declare that the information given is to the best of my knowledge and belief, full, true, and correct:

Signed _____ **Dated** _____

Authorization and Assignment of Benefits

I, the undersigned, authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information.
I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I *agree* that a photographic copy of this Authorization shall be as valid as the original.
I understand that I or my authorized representative may request a copy of this authorization.
I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative

_____

Relationship (if other than Insured) _____

Dated _____

Address_____

Patient's Signature and Release (Parent or Guardian, if claim is for a minor), I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine claim payment.

Signed _____ **Dated** _____

Please Email your completed claim form with legible documentation to:

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The following states have required us to use state specific language as follows:

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
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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.

Louisiana
Any person who knowingly presents a false or fraudulent claim for payment or 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.

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

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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Ohio
Any person who, with the 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 process of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon
Any person with the intent to knowingly 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 that is related to the acceptance of the risk by the insurer, may be guilty of insurance fraud and may be subject to prosecution.

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Pennsylvania
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 and subjects such person to criminal and civil penalties.

Virginia
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application containing any material misstatement, or files a claim containing a false or deceptive statement may have violated state law.

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Chubb Educational Travel Claim Form

Attending Physician Statement

Section A. Insured Information

Plan Purchased: _____ Policy Number: _____

Reason for claim: _____

Name: _____ Date of Birth: _____

Parent or Guardian (if under 18): _____

Home Address: _____

Home #: _____ E-mail: _____

Section B. Medical Information (To be completed by Physician Rendering Treatment)

Patient's Name: _____

Diagnosis: _____

Date symptoms or injury first occurred: _____

Date first consulted for this condition: _____

Has the patient ever had the same or similar condition? ☐ Yes ☐ No

If Yes, please provide the date of the condition: _____

Did you advise the trip to be cancelled due to the patient's medical condition? ☐ Yes ☐ No

If Yes, please provide details: _____

_____

_____

Does the patient's condition render them totally or partially disabled? ☐ Yes ☐ No

If Yes, Disability dates: **Total:** From _____ To _____ **Partial:** From _____ To _____

Was patient able to return to work? ☐ Yes ☐ No

If Yes, Return to Work Date: _____

If patient Hospital Confined, Hospital confinement dates: From _____ To _____

Hospital Name: _____

Section C. Declaration

I declare that the information given is to the best of my knowledge and belief, full, true and correct:

Physician Signature _____ **Dated** _____

I declare that the information given is to the best of my knowledge and belief, full, true and correct:

Signature of Insured or Authorized Representative _____

Relationship (if other than Insured) _____ **Dated** _____

Address _____

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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.

Louisiana
Any person who knowingly presents a false or fraudulent claim for payment or 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.

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

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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Ohio
Any person who, with the 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 process of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon
Any person with the intent to knowingly 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 that is related to the acceptance of the risk by the insurer, may be guilty of insurance fraud and may be subject to prosecution.

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Pennsylvania
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Virginia
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application containing any material misstatement, or files a claim containing a false or deceptive statement may have violated state law.

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Chubb Educational Travel
Accidental Death & Dismemberment Claim Form

Instructions

When reporting the claim please provide your name, Program ID number, type of claim, and mailing address to send the claim. Once you have completely filled out the appropriate sections of the claim form, it must be remitted back to *Administrative Concepts, Inc.* In addition to the claim form, there may be specific information required. In order to expedite your claim, please provide the applicable documentation based on the coverage(s) you are claiming listed below:

Accidental Death:

☐ Certified copy of the final death certificate

☐ Police report, any autopsy report, any medical records or reports, and any newspaper clippings

☐ Travel itinerary

Accidental Dismemberment:

☐ Police report, all medical records, any eyewitness statements and complete accident details

☐ Travel itinerary

Please Email your completed claim form with legible documentation to:

Administrative Concepts, Inc.
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Section A. Trip Information

Plan Purchased: _____ Policy Number: _____

Program ID Number: _____ Date of Booking: _____

Trip Departure Date: _____ Trip Return Date: _____

Reason for claim: _____

_____

_____

Section B. Insured Information

Primary Insured Name: _____ Primary Insured Date of Birth: _____

Parent or Guardian (if under 18): _____

Home Address: _____

Please provide telephone and facsimile numbers, with country and city codes.

Home #: _____ Work #: _____

Fax #: _____ E-mail: _____

Other Coverage Information

Do you have any other insurance? ☐ Yes ☐ No

If yes, please provide source of insurance: _____

_____

Are claim expenses recoverable from another source? ☐ Yes ☐ No

If yes, please provide details and amount: _____

_____

Section C. Payment Information (funds will be issued in U.S. Currency)

Payment to Insured, Guardian or Beneficiary.

☐ Your home address as listed above ☐ Direct deposit to your bank account

Name on account: _____

Bank Name: _____

Bank Address: _____

Account #: _____ Bank Routing # or Swift Code: _____

IBAN: _____

Please Email your completed claim form with legible documentation to:

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Section D. Accidental Injury or Death (see list of required documents on page 1)

Name: _____ Date and time of accident: _____

Give details of the accident: _____

_____

_____

_____

_____

Name and addresses of witnesses to accident:

_____

_____

_____

_____

_____

Diagnosis: _____

_____

If loss is sight, is loss in both eyes? ☐ Yes ☐ No

If loss is hearing, is loss in both ears? ☐ Yes ☐ No

If loss is speech, is loss total and irreversible? ☐ Yes ☐ No

If loss is extremity, where is severance? _____

Was the loss caused by an accident independent of all other causes? ☐ Yes ☐ No

Was the loss caused in any way by illness? ☐ Yes ☐ No

If yes, list dates you received treatment for this illness: _____

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Name and addresses of all physicians consulted

Primary Care Physician: _____

PCP City: _____ PCP State: _____ PCP Phone#: _____

Name: _____ Date of treatment: _____

Address: _____

Name: _____ Date of treatment: _____

Address: _____

What operation was performed? _____

If in a hospital, which one: From _____ To _____

If accident resulted in death, please fill out the below information:

Was there a judicial ruling made on the cause of death by a judge or jury? ☐ Yes ☐ No

If yes, please complete the following and attach a copy of the proceedings and verdict.

Name of person conducting autopsy: _____ Title: _____

Address: _____

First physician attending deceased after injury

Name: _____

Address: _____

Previous medical history

Primary Care Physician: _____

PCP City: _____ PCP State: _____ PCP Phone#: _____

Was deceased treated for any medical conditions within 5 years prior to accident? ☐ Yes ☐ No

If yes, please list physician(s) in attendance below.

Name: _____

Medical condition: _____

Dates of treatment: _____

Address: _____

Name: _____

Medical condition: _____

Dates of treatment: _____

Address: _____

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To be completed if death resulted from motor vehicle accident:

Type of Vehicle: _____ Registered Owner:_____

Was the deceased the driver? ☐ Yes ☐ No

Use of vehicle: ☐ Business ☐ Pleasure ☐ Business and Pleasure

Name of law enforcement agency investigating accident: _____

Address: _____

Section E. Declaration

I declare that the information given is to the best of my knowledge and belief, full, true and correct:

Signed _____ **Dated** _____

Authorization and Assignment of Benefits

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I *agree* that a photographic copy of this Authorization shall be as valid as the original.
I understand that I or my authorized representative may request a copy of this authorization.
I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative _____

Relationship (if other than insured) _____ **Dated** _____

Address_____

Patient's Signature and Release (Parent or Guardian, if claim is for a minor)

I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine claim payment.

Signature _____ **Dated** _____

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