iNext - Trip Cancellation

Claim Form & Claimant's Statement

PARTICIPANT'S INFORMATION:

School and Program Names: ______________________________

College/Department Number: ______________________________

Name(s) and birthdates of all claimants:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Email Address: ______________________ Home Phone #: (_______) ______________________

Work Phone: (________) ____________/______________ Cell #: (_______) ______________________

Address: ______________________ City: ____________________ State:____ Zip Code:________

TRAVEL SUPPLIER / PROVIDER INFORMATION:

Company Name: ______________________ Address: ______________________

City: ______________________ State: _____ Zip: ________

Contact: ______________________ Phone #: (_____)_________________

Date Travel Arrangements were made:_____/_____/_____

Date of initial payment deposit: _____/_____/_____

Scheduled Date of Departure: ____/____/_____ Scheduled Date of Return: ___/___/_____ Destination: _____________

If not included in package, how was air travel arranged? ______________________

LOSS INFORMATION:

After completing this section, attach copies of all travel documents (original airline tickets, hotel receipts, travel itinerary, tour cost, etc.) supporting penalties, nonrefundable charges incurred by you due to cancellation.

Company name: (airline/hotel/cruise/travel agent/etc.)	Amount paid:	Amount of loss: (non-refundable amount)	Have you received reimbursement?	If so, from whom?	How much?
	$	$	Yes No		$
	$	$	Yes No		$
	$	$	Yes No		$
	$	$	Yes No		$
Total	$	$			$

REASON FOR CANCELLATION:

Date Trip was cancelled with Travel Supplier: ____/____/_____ Reason for Cancellation:______________________________________

____

____

IF CANCELLATION IS DUE TO MEDICAL REASONS:

Name of person having sickness or injury: ____

His / Her date of birth: ___/_____/_____ His / Her relationship to claimant: ____

Date Sickness or Injury began: ____/____/_____ Date ended: ____/____/_____

Nature of Sickness or Injury (If Injury, describe accident, including date and place): ____

____

Period of hospitalization (If applicable): From: _____/_____/______ To: ____/_____/_____

To Be Completed by the Attending Physician:

Name of patient:____ Name of Doctor:________________________________

Address: ____

Office Phone #: (_____)____________________ Office Fax #: (______)______________________

Date of Birth: _____/______/______ Date symptoms first appeared or accident occurred: _____/______/______

Date of first treatment: ______/______/______ Date of last treatment:_____/______/______

List of all exam/treatment dates after initial consult: ____

____

Diagnosis: ____ Diagnosis Code:___________________________

Was patient treated by someone else?: YES / NO If so, by whom?: ____

When?: ___________________________

If patient is the traveler, did you prohibit patient's traveling: YES/NO: Date the traveler became disabled from Travel: ____/____/____

Has the patient received medication or other treatment for this condition, or for a related condition, by you or any other Physician during the 90 days immediately prior to the date the claimant purchased this protection plan (see page 1 for date of purchase)? If so, please provide exact dates and details:

____

____

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.

Date Completed: _____/_____/______ Physician's Signature: _______________________________________

Taxpayer ID Number: _______________________________________

Authorization For Release of Medical Information – To be Completed by Patient

In order to process a claim for benefits, I authorize any physician, hospital, or other Medical Provider to release to the Travel Insurance Claims Administrator, 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.

Date: ______________________ Signature: ____

(Signature of Person Suffering Illness or Injury or legally authorized representative)

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. We recommend you keep copies of any items submitted with this claim.

____ Copies of cancelled checks or credit card statements that shows all payments made for the trip with an invoice from your Travel Provider showing the total cost paid for the trip.

____ Proof of Cancellation/Refund from travel supplier

____ Airline Ticket Stub/Receipt (if applicable)

____ Police Report (if applicable)

____ Car Rental Agreement (if applicable)

____ 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.

____ Other (please describe): ____

____ Please advise if you wish to be contacted via e-mail or regular mail: ____________________________

OTHER INSURANCE / AUTHORIZATION:

Do you have any other type of insurance?____

If so, please provide the Company Name and Address:____

Type of Policy: _____________ Policy #: _____________ Contact: _________________ Phone: (____)______________

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 on page 4 of this document.

______________________________ ____________________

Signed Date

ASSIGNMENT OF BENEFITS:

I hereby ASSIGN all benefits to which I am entitled to school named above. I understand that I am responsible for any amount not covered by insurance.

______________________________ ____________________

Signed Date

MAILING INSTRUCTIONS:

Send this form and any accompanying documentation to:

Attention: Co-ordinated Benefit Plans, LLC
On Behalf of Nationwide Mutual Insurance Company and Affiliated Companies
P.O. Box 26222
Tampa, FL 33623
Or
E-mail your information to: Team1@cbpinsure.com

FRAUD STATEMENTS – If you reside in the state of:

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.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

District of Columbia: 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.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for 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 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.

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.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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: 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.

Missouri: An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

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.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."

All Other States: 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/or civil penalties.

EFFECTIVE DATE
This Notice is effective May 16, 2014.