IMG® Global Work & Travel Claim Form

Trip Cancellation / Curtailment

For All Claims

The following documentation is required to begin processing your claim:

- ☐ The fully completed claim form, signed and dated
- ☐ The complete trip itinerary & a copy of itemized invoice showing amount paid for trip
  Examples: e-ticket or paper ticket, hotel charges, service fees and other accommodation expenses
- ☐ Proof of payment for the trip
  Examples: credit card statement, cancelled check, common carrier and travel supplier receipts
- ☐ Statement from common carrier, travel supplier, or travel agency indicating if any refund, reimbursement, credit, and/or voucher was issued. If no refund, reimbursement, credit, or voucher was issued, a copy of the Cancellation terms and conditions must be provided to verify you are not entitled to reimbursement or credits from any other source
- ☐ Written proof from travel supplier verifying reservation was cancelled

For Medical Cancellation / Curtailment

If trip was cancelled or curtailed due to sickness, injury, or death, include medical documentation including but not limited to:

- ☐ Attending physician's statement (completed by the treating physician)
- ☐ Copy of death certificate (if applicable)
- ☐ Proof of relationship (if cancellation is due to the illness, injury or death of a family member)

For Other Reasons

If the trip was cancelled or curtailed due to other causes, include the additional documents to show proof of loss due to any of the "Other Covered Reasons" identified in the insurance contract:

- ☐ Fire marshal or insurance company report attesting to the fact the primary residence is uninhabitable

Travel Delay

The following documentation is required to begin processing your claim:

- ☐ A copy of the complete trip itinerary including all transportation details and ticket information
- ☐ A copy of the complete altered itinerary issued by the travel supplier or common carrier due to the delay, including reservation numbers
- ☐ Documentation from the travel supplier and common carrier (airline, cruise line, etc.) indicating the reason and length of the delay

Missed Departure and Journey Disruption

The following documentation is required to begin processing your claim:

Missed Departure

- ☐ A copy of the complete trip itinerary including all transportation details and ticket information
- ☐ A copy of the complete altered itinerary issued by the travel supplier or common carrier due to the delay, including reservation numbers
- ☐ Documentation from the travel supplier and common carrier (airline, cruise line, etc.) indicating the reason and length of the delay
- ☐ Documentation verifying any refunds, reimbursement, credits or vouchers issued by the travel supplier and common carrier following the delay
- ☐ Itemized receipts for additional expenses incurred due to the delay
- ☐ Proof of vehicle breakdown, such as tow service receipt or repair estimate
- ☐ Documentation of road traffic accident

Journey Disruption

- ☐ Local medical epidemic or directive from a qualified national or local authority directly affecting the area where the insured Person is traveling
- ☐ Letter from transportation authority attesting to hijacking report
- ☐ Documentation verifying terrorist incident (i.e., civil unrest and war) within 30 days of departure date in the city you were

scheduled to travel during the trip or proof of mandatory evacuation by local government authority at your trip destination due to Natural Disaster

- ☐ Fire marshal or insurance company report attesting to the fact the Member/Insured's primary residence is uninhabitable
- ☐ Proof of hurricane warning issued by National Hurricane Center at the trip destination within 24 hours of your scheduled trip
- ☐ Documentation from travel supplier outlining the reason and timeframe for cessation of services due to weather, strike, mechanical breakdown or natural disaster
- ☐ Documentation verifying insolvency of travel supplier led to cessation of travel services

Baggage: Lost, Stolen or Delayed

The following documentation is required to begin processing your claim

- ☐ Travel Itinerary: A copy of the original itinerary reflecting the ticket number(s), date and time(s) of the trip
- ☐ Refund: A copy of all documents that reflect amounts paid to you for the delay/loss
- ☐ Items: Provide a detailed list of the items lost, stolen, or damaged in the appropriate section of this form
- ☐ Receipts: Original receipts for items purchased resulting from delay. Original receipts are needed for items lost, stolen or damaged beyond repair. Proof of ownership must be submitted if original receipts are not available
- ☐ Incident Report: An irregularity report, incident report, or a copy of the initial loss report filed with the Common Carrier.
- ☐ Police Report: A copy of the police report is required for items stolen
- ☐ Settlement Statement: A copy of the finalized settlement statement from the entity (e.g. airline, cruise line, tour operator, home insurance, credit card, etc.) that received the incident report
- ☐ Damage Baggage Verification: A repair estimate or documentation from the entity making repairs. The repair estimate/ documentation must be on entity's stationery

PRIMARY CLAIMANT INFORMATION		
Insured's Name *(Last, First, Middle)*:	Policy Number:	
Mailing Address:		
Email Address:	Home Telephone Number *(with area code):*	Work Telephone Number *(with area code):*

PART 1. GENERAL INFORMATION

1. Full Name of Claimant: *(List all claimants. Attach additional sheets if necessary)*	Date of Birth *(dd, mm, yyyy):*
Policy Number:	Relationship to Insured:
2. Full Name of Claimant:	Date of Birth *(dd, mm, yyyy):*
Policy Number:	Relationship to Insured:
3. Full Name of Claimant:	Date of Birth *(dd, mm, yyyy):*
Policy Number:	Relationship to Insured:
4. Full Name of Claimant:	Date of Birth *(dd, mm, yyyy):*
Policy Number:	Relationship to Insured:

Name of Travel Supplier *(e.g. Cruise Line, Airline, etc.)*:

Travel Agency's Full Name:	Travel Agent's Name:	Telephone Number *(with area code)*:
Travel Agency's Mailing Address:		Email Address:

Initial Deposit Date Paid for Trip *(dd, mm, yyyy):*	Final Payment Date *(dd, mm, yyyy):*	Scheduled Departure Date *(dd, mm, yyyy):*	Schedule Return Date *(dd, mm, yyyy):*	Actual Return Date *(dd, mm, yyyy):*

Departure City:	Destination *(City, Country or State)*:

Please check box for benefits requested: ❑ Trip Cancellation ❑ Trip Curtailment

- If the cancellation and/or interruption/curtailment is due to sickness, injury, or death, please complete the entire claim form
- If the cancellation and/or interruption/curtailment is due to a non-medical reason(s), please complete Parts 2 and 4

PART 2. EXPLANATION OF LOSS

Describe in detail what occurred:

Date Trip Cancelled/Curtailed *(dd, mm, yyyy):*	Total paid for trip prior to cancellation (do not include travel insurance premium):	Total paid per insured prior to cancellation *(US$):*
Total paid for original airfare, per insured (include only if unused airfare is part of the loss claimed):	Did you receive a refund, reimbursement, voucher, or credit from the Travel Agent, common carrier, or travel supplier? ❑ Yes ❑ No	If Yes, please list amount refunded/credited *(US$):*

Additional losses claimed due to Cancellation/Curtailment:

Type of Expense incurred (hotel, transportation, new tickets):	Date Incurred *(dd, mm, yyyy):*	Amount *(US$):*
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
Please use a separate sheet of paper for any additional expenses. Proof of payment is required for all losses claimed. Claims cannot be processed without proof of loss.		
	Total Amount of Cancellation/Curtailment Claim:	

PART 3. MEDICAL INFORMATION - Complete for Cancellation/Curtailment due to Sickness, Injury, or Death.

Patient's Name:	Relationship to Insured:	Date Symptoms First Noticed *(dd, mm, yyyy):*
Nature of Illness:		Date of First Consultation *(dd, mm, yyyy):*
Describe onset, diagnosis and treatment:		
For Injury, describe Injury:		Date of First Consultation *(dd, mm, yyyy):*
How and where did the accident occur:		
If hospitalized, hospital name, website and address:		Dates of Confinement *(dd, mm, yyyy):* From: To:
Name and Address of Treating Physician:		Telephone Number *(with area code):* Fax Number *(with area code):*

PART 4. OTHER COVERAGE

Do you have any other insurance or coverage related to the loss *(e.g. medical, travel, etc.)?*	❑ Yes ❑ No
Do you have any travel other insurance coverage *(i.e. through credit card used to purchase items)?*	❑ Yes ❑ No
Did you report the loss to any other insurance company?	❑ Yes ❑ No

If Yes, which company:

Name of Company:	Policy/Certificate Number:	Telephone Number *(with area code):*	Website:
1. _____ Address:_____ _____	_____	_____	_____
2. _____ Address:_____ _____	_____	_____	_____
3. _____ Address:_____ _____	_____	_____	_____
(Please attach a separate sheet if necessary)			

PART 5. CERTIFICATE OF MEDICAL CONDITION/MEDICAL PROVIDER'S STATEMENT

Patient's Name:	Date of Birth *(dd, mm, yyyy):*
Insured's Name:	Patient's Relationship to Insured:
Policy Number:	Policy Purchase Date*(dd, mm, yyyy):*

ATTENDING PHYSICIAN'S STATEMENT. MUST BE COMPLETED AND SIGNED BY THE PHYSICIAN.

1. Diagnosis: Nature of Sickness/Injury causing Cancellation/Curtailment *(Please be specific)*:
   - **a.** Primary Diagnosis of ICD-9 code_____
   - **b.** Secondary Diagnosis of ICD-9 code _____

2. When did symptoms of sickness or injury first occur *(dd, mm, yyyy)?*

3. When did the patient first consult you for this condition *(dd, mm, yyyy)?*

4. If patient was referred from another provider, name of provider, address and telephone number *(with area code):*

5. Name, address, and telephone number of other medical personnel involved:

6. Was there any medical condition, injury, illness, or sickness that would interfere with the insured's trip? ❑ Yes ❑ No
If Yes, please explain and indicate when patient was determined not to be medically fit to travel: _____

7. List all dates of treatment and services for this condition

Date of Services *(dd, mm, yyyy):*	Describe the Condition/Treatment:
(Please attach a separate sheet if necessary)	

8. Has the patient been hospitalized for this condition or related condition(s)? ❑ Yes ❑ No
If Yes, date of first admission *(dd, mm, yyyy):* Date of discharge *(dd, mm, yyyy):*

9. On what date did this condition first prevent or restrict the patient from traveling *(dd, mm, yyyy)?*

10. On what date would the patient not be restricted and medically fit to travel *(dd, mm, yyyy)?*

11. Did you advise the insured to cancel travel plans prior to departure or return home early a result of the sickness or injury?
❑ Yes ❑ No If Yes, on what date *(dd, mm, yyyy)?* Please explain:
If No, on what date was the insured prevented from participating in the trip *(dd, mm, yyyy)?*

12. If condition was related to pregnancy, date of conception *(dd, mm, yyyy)?* Expected Delivery Date *(dd, mm, yyyy)?*

13. Was this Sickness/Injury the sole cause of the patient's medically imposed restrictions? ❑ Yes ❑ No
If No, please explain:

Additional Physician comments:

Signature of Physician:	Date Completed *(dd, mm, yyyy):*
Name of Physician:	Telephone Number *(with area code):*
Address of Physician:	
Taxpayer ID Number:	Fax Number *(with area code):*

PART 6. PAYMENT DETAILS- TO PRIMARY INSURED

Account Holder's Name:		
Bank Name:		
Bank Address:	City:	Country:
Currency of Reimbursement:	Bank 9 digit ABA Number - U.S. Banks:	
Bank 8 or 11 digit SWIFT Code - Non- U.S. Banks:	SORT code:	
Bank account number:	Bank IBAN:	
Intermediary Bank Details *(If Applicable):*		
Name of Intermediary Bank:		
Intermediary Bank SWIFT Code:	Intermediary Bank Account Number:	

AUTHORIZATION

The undersigned understands a valid authorization is required for any use or disclosure of PHI not required or otherwise permitted without authorization by applicable privacy and confidentiality laws. The undersigned authorizes any health plan, health care provider, health care professional, MIB, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency, employer, benefit plan, or any other organization or person that has provided care, advice, diagnosis, payment, treatment, or services to the insured or on the insured's behalf, has any records or knowledge of the insured's health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the insured, and any non-medical information about the insured, to disclose the insured's entire medical record, file, history, medications, and any other information concerning the insured and to give any and all such information to the insured's agent of record and authorized representatives of the insurer, IMG, and their affiliates, and subsidiaries. This information will be used to evaluate claims for benefits. Individuals have the right to refuse to sign the authorization without negative consequences to treatment or plan enrollment, except IMG will not be able to administer claims, determine benefit eligibility, or issue payments. The authorization is valid for the term of the insurance contract or plan under which a claim has been submitted. The undersigned understands that the insured has the right to receive a copy of this authorization upon request and revoke the authorization at any time in a written communication to IMG. A copy of this shall be as valid as the original. The undersigned acknowledges and understands that we will handle any information we receive as a result of this authorization according to our Privacy Policy, which is available to review online.

The undersigned represents and warrants information or documents provided to IMG by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees: 1) any insurance coverage or benefit is contingent upon any statement made to IMG as being complete and correct, and 2) benefits under any contract will be paid only if IMG decides the applicant is entitled to them.

Any person who knowingly presents a false or faudulent claim for payment of a loss of 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.

** ATTENTION: IF YOU ARE CLAIMING AIRLINE TICKETS, PLEASE COMPLETE THE SECTION BELOW.**
Your airline tickets may have value for up to one year from the original scheduled travel date. Please indicate below whether you will be exchanging your ticket for another trip. Please note: Your signature on this agreement is not a guarantee of payment. All final claim determinations are subject to eligibility and the terms of the policy.

__ I (We) will not be using our airline ticket(s). (Please include a copy of your electronic ticket confirmation(s) which includes your ticket number(s).

__ I (We) will be exchanging our airline ticket(s) for future travel. (Please submit documentation of the cost you incurred or will incur to exchange your ticket(s).)

Signature of Insured/Claimant:	Date *(dd, mm, yyyy):*
Signature of Insured/Claimant:	Date *(dd, mm, yyyy):*
Signature of Insured/Claimant:	Date *(dd, mm, yyyy):*
Signature of Insured/Claimant:	Date *(dd, mm, yyyy):*

Send by one of the following secure methods:
Secure Message Center: www.imglobal.com/secure-message-center
Encrypted Email: insurance@imglobal.com
Fax: +1.317.655.4505