

Trip Interruption Claim Form

TRAVELER INFORMATION

<p>Name 1 <u>Charles</u> <u>Kevin</u> <u>Dammon</u></p> <p style="font-size: small; margin-left: 20px;"> Prez First Middle Last Sufz </p> <p>Mailing Address <u>124 Eden Isles Drive</u></p> <p style="font-size: small; margin-left: 20px;">Street Address</p> <p>Sidell <u>LA</u> <u>USA</u> <u>70458</u></p> <p style="font-size: small; margin-left: 20px;"> City State/Province Country Postal Code </p> <p>Below, please enter the Name, Gender, Date of Birth and Relationship to Name 1 of other persons in the household who have a claim.</p> <p>Name 2 <u>Jacqueline</u> <u>Koch</u> <u>Morel</u></p> <p style="font-size: small; margin-left: 20px;"> Prez First Middle Last Sufz </p> <p>Name 3 _____ _____ _____</p> <p style="font-size: small; margin-left: 20px;"> Prez First Middle Last Sufz </p> <p>Name 4 _____ _____ _____</p> <p style="font-size: small; margin-left: 20px;"> Prez First Middle Last Sufz </p>	<p>Gender Date of Birth</p> <p>M <input checked="" type="checkbox"/> F <input type="checkbox"/> 9 / 3 / 1962</p> <p>Daytime Telephone # (985) 640 7891</p> <p>Evening Telephone # (985) 640 7891</p> <p>Preferred Contact Number x Day x Evening</p> <p>Gender Date of Birth Relation to Name 1</p> <p>M <input type="checkbox"/> F <input checked="" type="checkbox"/> 4 / 24 / 1969 Traveling Companion</p> <p>M <input type="checkbox"/> F <input type="checkbox"/> ____ / ____ / ____ _____</p> <p>M <input type="checkbox"/> F <input type="checkbox"/> ____ / ____ / ____ _____</p>
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TRIP INFORMATION

Date You Purchased Protection Plan 8 / 2 / 2018 Attach a copy of the front and back of your canceled check or a copy of your credit card statement showing your protection plan purchase.

Name of Tour Operator/Cruise Line/Travel Agency Unique Vacations (Sandals & Beaches) Booking/Invoice # 11014213

Tour/Cruise Name and Number sandals royal caribbean Primary Trip Destination(s) Jamaica

Scheduled Trip Information: Scheduled Trip Departure Date 8 / 31 / 2018 Scheduled Trip Return Date 9 / 4 / 2018

Trip Departure City New Orleans Trip Return City New Orleans

Date of Initial Deposit for Trip 8 / 2 / 2018 Date of Final Payment for Trip 8 / 2 / 2018

Did you book through a travel agent/agency? Yes No If yes, Agency Name Seven Seas Travel

Agent Name Teri McGovern Telephone No. (985) 643 6958 E-mail Address sevenseatravel@aol.com

Is there any other insurance or protection plan covering this trip? Yes No If yes, Policy or Plan No. _____

Name of other insurer _____ Telephone No. () _____ Claim No. _____

INFORMATION ABOUT YOUR INTERRUPTION

This request for reimbursement of covered expenses is for the following event(s) (check appropriate boxes):

<input type="checkbox"/> Delayed arrival on your trip	Date you were able to join your tour/cruise: _____ / _____ / _____
<input checked="" type="checkbox"/> Trip interruption after departure	Date you left tour/cruise: <u>8 / 31 / 2018</u>
	If you rejoined the tour/cruise, please indicate date: <u>9 / 5 / 2018</u>

Original Trip Cost \$ 3282.10 Supplier Refunds Received or Due \$ 469.20

Your Interruption is the result of: Sickness Injury Death of one of the following:

- a Claimant
- a traveling family member
- a non-traveling family member or Business Partner
- an unrelated traveling companion

Circumstances other than Sickness, Injury or Death (Describe reason(s) below)

Approaching Hurricane

If interruption is the result of sickness, injury or death complete the following additional information:

Name of sick, injured or deceased person	Relationship to You
If sickness or injury: Date sickness/injury began / /	Date sickness/injury ended / /
If death: Date of death / /	(Include certified copy of death certificate, funeral notices, obituaries, etc.)

Was the sick/injured/deceased person booked to share accommodations with you in the same room? Yes No

Nature of sickness, injury or cause of death (provide details about your sickness or describe the accident / injury, including date and place).

Any prior treatment or consultation for this sickness / injury? Yes No Date of last treatment ____/____/____

Was sickness or injury the sole cause of the trip interruption? Yes No If No, explain below

INFORMATION ABOUT CARE PROVIDERS

Contact information for the primary care physician:

Physician Name	Street Address	City, State//Province, Country, Postal Code	()	Telephone #
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Contact information for any other physicians or medical suppliers from whom treatment was received:

Name	Street Address	City, State//Province, Country, Postal Code	()	Telephone #
Name	Street Address	City, State//Province, Country, Postal Code	()	Telephone #
Name	Street Address	City, State//Province, Country, Postal Code	()	Telephone #

If hospitalized, contact information for hospital(s) and dates conducted:

Hospital Name	Street Address	City, State//Province, Country, Postal Code	()	Telephone #
Date Hospitalization Began / /	Date Hospitalization Ended / /			
Hospital Name	Street Address	City, State//Province, Country, Postal Code	()	Telephone #
Date Hospitalization Began ____/____/____	Date Hospitalization Ended ____/____/____			
Hospital Name	Street Address	City, State//Province, Country, Postal Code	()	Telephone #
Date Hospitalization Began ____/____/____	Date Hospitalization Ended ____/____/____			

Charles Dammon
 124 Eden Isles Drive
 Slidell LA, 70458

Trip Mate, Inc.*
 9225 Ward Parkway, Suite 200
 Kansas City, MO 64114

In CA & UT, dba Trip Mate Insurance Agency
 7292 (Toll-Free) Fax: 1-816-523-3379 E-mail: mail@travelclaims

If your interruption or delayed arrival was due to a carrier delay or cancellation, please complete:

Scheduled departure time: 15 : 10 AM PM Scheduled departure date: 9 / 4 / 2018
 Actual departure time: 15 : 10 AM PM Actual departure date: 9 / 5 / 2018
 Reason for delay/cancellation Hurricane approaching
 Name of carrier Spirit Airline Flight / Train / Bus # 270
 From Jamaica City To F.T. Lauderdale City
 Please provide documentation of your carrier delay or cancellation.

If you incurred additional transportation/hotel expense or had unused land/water expense, please complete:

Unused Land Accommodation Expenses:

Name and address of hotel, motel: Sandals P.O. Box 167 Mahoe Bay, St. James Jamaica
 Dates of Stay from: 9 / 4 / 2018 to 9 / 5 / 2018 Amount paid: \$ 450.00
 Name and address of hotel, motel: _____
 Dates of Stay from: / / to / / Amount paid: \$

Unused Water Accommodations:

Name of Cruise Line: _____
 Cruise Days Lost from: / / to / / Amount paid: \$

Additional Airfare Expenses:

Name of airline _____ Flight number _____ Date of service: / /
 Departed from: _____ to _____ Fare: \$
City/Country City/Country
 Name of airline _____ Flight number _____ Date of service: / /
 Departed from: _____ to _____ Fare: \$
City/Country City/Country

Additional Land/Water Transport Expenses:

Name of Carrier _____ Date of service: / /
 Departed from: _____ to _____ Fare: \$
City/Country City/Country

Additional Land Accommodation Expenses:

Name and address of hotel, motel: Sandals P.O. Box 167 Mahoe Bay, St. James Jamaica
 Dates of Stay from: 9 / 4 / 2018 to 9 / 5 / 2018 Amount paid: \$ 450.00
 Reason land expenses incurred:

Total Amount Being Claimed: \$ 900.00

Provide documentation (i.e. tickets, receipts, bills, etc.) for all of the above expenses.

If you need more space, please use a separate sheet of paper.

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Important Information (Please read and sign)

Fraud Warning: Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

To determine eligibility for claim benefits, claim payment amounts, and identification and prevention of potential fraudulent activity, the insurance company(ies) underwriting your policy, or its representatives, may disclose the claims information submitted to the insurance company(ies), or its representatives, to any insurance support organization or fraud information clearinghouse utilized by the insurance company(ies), or its representatives.

**** ATTENTION: IF YOU ARE CLAIMING AIRLINE TICKETS, PLEASE COMPLETE THE 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).)

Please review the claim form to make sure all of the information provided is accurate and complete and that all required documentation is included and sign below.

All statements contained in this form are true and complete to the best of my knowledge.

Date Completed: 09 / 11 / 18

Your Name: CHARLES DAMMON

Your Signature: *Charles Dammon*

FR-02-14

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To determine eligibility for claim benefits, claim payment amounts, and identification and prevention of potential fraudulent activity, the insurance company(ies) underwriting your policy, or its representatives, may disclose the claims information submitted to the insurance company(ies), or its representatives, to any insurance support organization or fraud information clearinghouse utilized by the insurance company(ies), or its representatives.

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Authorization For Release Of Information

In order to determine eligibility for claim benefits, claim payment amounts, and identification and prevention of potential fraudulent activity:

1. I authorize any physician; hospital or other medical or medically related facility or provider; insurance company; insurance support organization, travel supplier or fraud information clearinghouse to release to: United States Fire Insurance Company, its representatives or business associates assisting in the processing of the claim, any information regarding my medical history, symptoms, treatment, examination results or diagnosis or such other information needed to determine claim benefits; and
2. I authorize United States Fire Insurance Company, its representatives or business associates assisting in the processing of my claim, to disclose the claims information submitted to United States Fire Insurance Company, its representatives or business associates assisting in the processing of my claim, to any insurance support organization or fraud information clearinghouse utilized by United States Fire Insurance Company, or its representatives or business associates. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for a period not to exceed one year from the date signed. I understand I have the right to receive a copy of this authorization and that I may revoke this authorization at any time for information not then obtained upon my providing written notice of such revocation of the authorization to United States Fire Insurance Company, its representatives or business associates assisting in the processing of my claim.

Date Completed: ___ / ___ / ___

Patient's Name: _____
FIRST NAME MIDDLE INITIAL LAST NAME

Signature of Patient: _____

Patient's Date of Birth: ___ / ___ / ___

APS-ARI-USF-02-14

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ATTENDING PHYSICIAN'S STATEMENT

This form must be completed in full by the treating physician

Patient's name _____ D.O.B. ____ / ____ / ____

Diagnosis _____ ICD10 Code _____

Date of onset ____ / ____ / ____ Date first seen for this complaint ____ / ____ / ____

Has patient ever had treatment for same or similar condition? _____ When? _____

Dates of hospitalization (if any) ____ / ____ / ____ through ____ / ____ / ____
 ____ / ____ / ____ through ____ / ____ / ____

Surgical procedures (if any) and dates performed: _____

List other treatment/consultation and dates performed: _____

Medications prescribed: _____

Name of referring physician: _____ When Referred? _____

List other physicians treating patient for this condition.

Name _____ When? _____

Name _____ When? _____

If patient is the traveler, did this condition disable him/her from travel? Yes No

Inclusive dates of disability: From ____ / ____ / ____ through ____ / ____ / ____

If patient is a non-traveling family member, indicate dates the family member's care and attendance was required:

From ____ / ____ / ____ through ____ / ____ / ____

Any false or misleading statement made in support of and resulting in a benefit payment shall be subject to legal action for collection of damages against the person or persons making such false and/or misleading statements.

Date completed ____ / ____ / ____ Physician's signature _____

Physician name _____ Physician telephone (____) _____

Physician address _____ Physician facsimile (____) _____

_____ Tax identification # _____

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Return This Form To:

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