Broadspire
A CRAWFORD COMPANY

Underwritten by
STARR
INSURANCE COMPANIES

Trip Cancellation/Interruption/Delay - Medical Claim Form

SECTION A - CONTACT INFORMATION

Please choose one of the following:

TRIP CANCELLATION ☐ TRIP INTERRUPTION ☐ TRIP DELAY ☐

MISSED CONNECTION ☐ SINGLE OCCUPANCY SUPPLEMENT ☐

Name of insured _____ (FIRST / LAST) Date of birth _____ (MM / DD / YYYY)

Home Telephone _____ Work Telephone _____

Home Address _____ City _____

State /Jurisdiction _____ Postal/ Zip Code _____ Email Address _____

Mailing Address _____ City _____

State /Jurisdiction _____ Postal/ Zip Code _____

Preferred method of contact: Mail ☐ Email ☐ Home Phone ☐ Work Phone ☐

SECTION B - PLAN INFORMATION

Confirmation/ Policy ID # _____

Booking # _____

Date of departure _____ (MM / DD / YYYY) Date of Return _____ (MM / DD / YYYY)

Original Destination Travel _____

Agency Name _____

Initial Deposit Date _____

Agent's Name _____

Agent's Phone Number _____

Agent's Email _____

SECTION C - TRAVELING COMPANIONS

Companion Name _____ (FIRST / LAST) Companion Name _____ (FIRST / LAST)

Policy Number _____ Policy Number _____

SECTION D - OTHER INSURANCE INFORMATION

Do you have any other travel or out-of-country medical insurance?

☐ YES ☐ NO

If yes, please indicate name of insurance company: _____ Policy no. _____

Credit card issuing bank: _____ Cardholder name: _____

SECTION E - CLAIMED EXPENSES

Category	Amount	Required Support Documents*
Airfare	$	E-ticket receipt or original paper airline tickets
Lodging	$	Documents confirming your reservation/ payment/ partial payment
Tour(s)	$	Copy of the invoice
Cruise Ship	$	
Other	$	
Total Expenses	$	
Less Refunds	$	Examples: account credits, cash refunds, trip or meal voucher, etc.
Total Claimed	$	

(a) * We reserve the right to request additional information/ documentation as needed to process the claim.

SECTION F - REQUIRED SUPPORTING DOCUMENTS*(a)

1) Completed claim forms (signed and dated);
2) Complete Travel Itinerary (i.e., flight schedule, hotel confirmation or tour/cruise itinerary);
3) Proof of payment(s) for the trip
   (i.e., itemized travel invoice, e-ticket or paper ticket, hotel charges, service fees and other accommodation expenses or credit card statements);
4) Confirmation of the reason for the Trip Cancellation, Interruption, or Delay
   (i.e., completed physician statement, confirmation of death of immediate family member or documentation confirming any other non- medical cause of loss);
5) Cancellation letter from tour operator/agency/carrier (with cancellation policies);
6) Penalty terms from the affected travel company, carrier, lodging or other provider;
7) Documentation showing any refunds (if applicable);
8) Receipts for any additional/out of pocket expenses*(b);

*(b)Note: Reimbursement of same limited by policy terms and conditions

9) Medical Records from treating physician and/or signed HIPAA medical records release form, (if applicable)

(a) * We reserve the right to request additional information/ documentation as needed to process the claim.

SECTION G - AUTHORIZATION

FAILURE TO SIGN AND DATE MAY DELAY THE REVIEW OF YOUR CLAIM.

FRAUD WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, who files a statement of claim containing any false information, or conceals for the purpose of misleading, Information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to criminal prosecution, civil penalties and forfeiture of insurance benefits.

AUTHORIZATION

I AUTHORIZE any insurance company, physician, hospital, and other health care providers, any travel organization or agency, airline carrier, rental agency, hotel, motel, or similar entity providing lodging on a rental/lease basis or any other person who may have knowledge regarding this claim, to release any information requested to Broadspire and/or their affiliate partners regarding this claim and the loss reported.

By signing this claim form, I certify that all information given above is true and complete to the best of my knowledge. Signature:

_____ Date Signed: ____/____/_____

Print Name: _____

Create a profile and file your claim online using the link below:
https://myclaimsagent.com/starrjhia

Review status of active claims and upload documents here:
https://myclaimsagentupload.crawco.com

Fax: (855) 830-3728

Or, mail the completed and signed claim form and all required documents to:
Claim Benefit Services
P.O. Box 459084
Sunrise, FL 33345

If you choose to mail your documents, please send a copy of your documents and retain the originals for your records. Claim Benefit Services is unable to return any submitted documents. You will be contacted by a claim adjuster if additional information or documentation is required.

SECTION H - ILLNESS / ACCIDENT STATEMENT - TO BE COMPLETED BY PATIENT

Name of person having sickness or injury: _____ Date of Birth: _____ MM/ DD / YYYY

Relationship to Insured: _____ Social Security Number (of sick/injured person): _____

(See page 6 for additional information concerning this request)

Effective Date of Policy: _____ MM/ DD / YYYY

Date Sickness or Injury Began: _____ MM/ DD / YYYY Date Sickness/Injury Ended: _____ MM/ DD / YYYY

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

Period of Hospitalization - From: _____ MM/ DD / YYYY To: _____ MM/ DD / YYYY

Authorization For Release of Medical Information

In order to process a claim for benefits, I AUTHORIZE any physician, hospital, or other Medical Provider to release to Broadspire Claim Services, 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.

Signature _____ Date _____ MM/ DD / YYYY

SECTION I - PHYSICIAN'S STATEMENT - TO BE COMPLETED BY PHYSICIAN

If treatment received outside the United States please send medical report in place of this form.

Name of Doctor: _____ Address: _____

Office Phone #: _____ Fax #: _____

Name of Patient _____ Age _____

Was patient treated by someone else? Yes ☐ No ☐ Date first treated: _____ MM/ DD / YYYY

Date symptoms first appeared or accident occurred: _____ MM/ DD / YYYY Name(s) of other treating Physician(s): _____

Was the patient's medical condition stable at the time the insurance was purchased? Yes ☐ No ☐ Not Applicable ☐
(See **EFFECTIVE DATE of policy** in Section H above) (Condition was not present on date the insurance was purchased)

Was patient prohibited to travel due to this injury/illness? Yes ☐ No ☐ Not Applicable (Patient was not booked to travel with insured for this trip) ☐ If marked NA - was insured required to curtail or cancel trip to take care of patient? Yes ☐ No ☐

If so, when? _____ Please explain: _____

Has the patient received medication or other treatment for this condition, or for a related condition, by you or any other Physician during the ***60 days** immediately prior to the date the claimant purchased this protection plan?

***180 Days** for NV and WV residents (see above for **EFFECTIVE DATE of policy**)? Yes ☐ No ☐

If yes, 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 making such false and / or misleading statements.

*Signature _____ Date Completed _____ MM/ DD / YYYY

*Please provide authentication of physician signature- physician stamp, physician credentialing information, letterhead of practice or other form of authentication

HIPAA Compliant Authorization To Release Confidential Medical Information

Records and information obtained will be disclosed to the third party administrator, Broadspire, P.O. Box 459084, Sunrise, FL 33345

The purpose of this disclosure is to evaluate my application for insurance or claim benefits. I hereby authorize for you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all medical and non-medical records and information regarding me are to be released, including, but not limited to, financial, employment, police, complete driving and motor vehicle related records, as well as those relating to past and present illnesses, diagnosis, testing, treatments, and prognosis related to my physical and mental conditions. Such records and information to be released may include, but not be limited to, the following: alcohol abuse treatment and counseling, drug abuse treatment and counseling, psychiatric treatment, pharmacy prescriptions, Acquired Immune Deficiency Syndrome (AIDS), HIV testing and treatment, STD testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKG's.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, ("My Providers"), employers, financial custodians, law enforcement agencies, governmental agencies, medical examiners/ coroners, insurance companies, MIB, Inc. or anyone else located at:

Facility Name:_____Telephone #_____

Address:_____City_____State_____Zip_____

To release any and all records and information regarding:

Patient's Name:_____
First Middle Last

Other Names Used:_____

Date of Birth (MM/DD/YYYY):_____ Social Security Number:_____-_____-_____

Specifics to be released:_____

To be released to and exchanged between the claim administrator first named above, and/or the following companies:

The Records Company (TRC), Research Service Bureau (RSB)

Other:_____

and their agents, contractors, employees, representatives, affiliates, and assigns as necessary to fulfill the purpose of this disclosure.

I understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may become subject to further disclosure by the insurance company. For example, the insurance company may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this Authorization. This Authorization will remain in effect a maximum of six (6) months from my date of signature below. I understand I may revoke this Authorization at any time by requesting such of Broadspire Services in writing at its address stated above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this authorization to release my complete medical records, my insurance company may not be able to process my application for coverage, or if coverage has been issued, may not be able to process any benefit payments. I further understand that My Providers cannot condition treatment, payment, or eligibility for benefits on whether I sign this Authorization.

Signature of patient/guardian/personal representative: _____ **Date:**_____

Legal relationship to applicant:_____
(Only if signed above by guardian or personal representative)

Witness signature:_____ **Witness Required**
(Only if required) **(only if marked)**

Notary signature:_____ **Notary Required**
(Only if required) **(only if marked)**

IMPORTANT NOTICE CONCERNING THE COLLECTION OF YOUR PERSONALLY IDENTIFIABLE INFORMATION

Broadspire Services, Inc., a subsidiary of Crawford & Company, is a third party administrator assigned to act on behalf of Starr Indemnity & Liability Company, to process your claim.

Please be advised that your claim cannot be finalized without the ill/injured person's Social Security Number and Date of Birth as the claims administrator for Starr Indemnity & Liability Company will be unable to meet the mandatory reporting requirement outlined below.

The Center for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program.

Section 111 of the Medicare , Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law, was amended and effective July 1, 2009, requires that liability insurers (including self-insurers), no fault insurers , and workers compensation plans report specific information about U.S. citizens, permanent residents, temporary working residents and other social security enrolled individuals who have other insurance coverage.

Information must be reported before payments are made for certain treatment or when certain claimants receive a settlement, judgment or award as a result of a claim. The purpose of requiring reporting of such information is to prevent CMS from paying for medical treatment that another party may potentially be responsible for paying. In addition, this reporting allows CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

As a social security enrolled individual, specific information must be obtained and reported to Centers for Medicare and Medicaid Services before we can process your claim payment. Please note that this information is required of all social security enrolled individuals, even those who are not current Medicare beneficiaries.

Please do not email this information as email is not a secure method of transmission for personally identifiable information.

For fastest service, please upload the required document to our secure website:
https://myclaimsagentupload.crawco.com

Or you may mail the required document to:
Claim Benefit Services
P.O. Box 459084
Sunrise, FL 33345

Fax: 855-830-3728

Fraud Statements

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.

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.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Maryland, West Virginia: 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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 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 Agencies.

Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Delaware, Idaho, Indiana: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: Warning: 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 an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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. 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.

Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another 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 the person to criminal and civil penalties.

Minnesota; A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

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 section 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 penalties.

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: WARNING: 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.

Oregon: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law. 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.

Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: 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.