Claim Filing Instructions

Read the instructions for the type of claim you need to file, you may have more than one.

Trip Cancellation

You were unable to depart on your covered trip.

1. Complete all applicable information starting on page 2.
2. If cancellation was the result of an illness/injury, please have the patient's physician complete the "Physician's Statement" on the attached form.
3. Please submit proof of payment for claimed expenses. Acceptable forms of proof of payment include a credit card statement and/or a copy of the front and back of the negotiated check.
4. Copies of the invoice/reservation for hotel, cruise, and tour bookings.
5. Airline e-ticket.
6. Travel supplier cancellation notice. This notice should contain the reservation/itinerary/booking information, date of cancellation, and the penalties.

Trip Interruption

You started on your trip and then had to return home due to an unforeseen event.

1. Complete all applicable information starting on page 2.
2. If the interruption was the result of an illness/injury, please have the patient's physician complete the "Physician's Statement" on the attached claim form – medical records from the date of service are applicable in lieu of a completed "Physician's Statement".
3. Please submit proof of payment for claimed expenses. Acceptable forms of proof of payment include a credit card statement and/or a copy of the front and back of the negotiated check.
4. Copies of all original invoice/reservations for hotel, cruise, and tour bookings.
5. Airline e-ticket (please include original and new flight itineraries).

Trip Delay & Missed Connection

You started your trip and were delayed en route to, from, or during your scheduled trip.

1. Complete all applicable information starting on page 2.
2. Provide documentation from the common carrier (airline, cruise line, etc.) confirming the reason, and length of the delay.
3. Include purchase receipts for additional expenses incurred as a result of the delay.
4. Include airline itineraries (please include the original, and revised flight itineraries).

Trip Cancellation For Any Reason

You purchased this option and you canceled your trip for any reason not otherwise covered.

1. Complete all applicable information starting on page 2.
2. If cancellation was the result of an illness/injury, please have the patient's physician complete the "Physician's Statement" on the attached form.
3. Please submit proof of payment for the claimed expenses. Acceptable forms of proof of payment are a credit card statement and/or a copy of the front and back of the negotiated check.
4. Copies of the invoice/reservation for hotel, cruise, and tour bookings.
5. Airline e-ticket.
6. Travel supplier cancellation notice. This notice should contain the reservation/itinerary/booking information, date of cancellation, and the penalties.

Single Supplement

Booked a trip with a companion that has canceled resulting in additional charges.

1. Complete all applicable information starting on page 2.
2. Please submit all revised booking confirmations showing the revised total cost.

1 Reason for Claim

☐ Trip Cancellation ☐ Trip Interruption ☐ Trip Delay & Missed Connection
☐ Single Supplement ☐ Trip Cancellation For Any Reason

You may check more than one.

Primary Insured's Information

2 Name of Primary Insured	**3** Date of birth MM/DD/YYYY		
4 Policy number	**5** Preferred phone number		
6 Email address	**7** Fax number		
8 Mailing address (if different than home)	**9** City	**10** State	**11** Zip code
12 Home address	**13** City	**14** State	**15** Zip code
16 Preferred method of contact: ☐ Mail ☐ Email ☐ Phone			

Travel Supplier / Provider Information

17 Company name	**18** Phone number		
19 Company mailing address	**20** City	**21** State	**22** Zip code
23 Date travel arrangements were made MM/DD/YYYY	**24** Date of initial payment deposit MM/DD/YYYY		
25 Scheduled date of departure MM/DD/YYYY	**26** Scheduled date of return MM/DD/YYYY		
27 Actual date of return MM/DD/YYYY (trip interruption/trip delay)			

Claimed Expenses

Category	Amount	Required Supporting Documents
28 Airfare	$	E-ticket receipt or original paper airline tickets
29 Lodging	$	Documents confirming your reservation/payment/partial payment
30 Tour(s)	$	Copy of the invoice
31 Cruise ship	$	Booking confirmation
32 Other	$	Meals, taxi, any additional expenses
33 Total expenses	$	
34 Refunds	$	Examples: account credits, cash refunds, trip or meal voucher, etc.
35 Total claimed	**$**	

36 If You Are Claiming Airline Tickets, Please Complete The Below Section

Your airline tickets may have value up to one year from the original scheduled departure date. Please indicate below whether you will be exchanging your tickets for another trip. Please note: Your signature on this agreement is not a guarantee of payment. Claim determinations are subject to the terms and conditions of the plan document.

☐ I (We) will not be using our airline ticket(s). Please enclose a copy of all electronic ticket confirmation(s).

☐ I (We) will be exchanging our airline ticket(s) for future travel. Please enclose a copy of all electronic ticket confirmation(s) along with documentation for the cost you incurred for the exchange.

Traveling Companions

37 Companion name	**38** Policy number
39 Companion name	**40** Policy number
41 Companion name	**42** Policy number
43 Companion name	**44** Policy number

45 Reason for Cancellation / Delay / Interruption

If Cancellation / Delay / Interruption Due To Medical Reasons

46 Name of person having sickness or injury	**47** Date of birth MM/DD/YYYY
48 Relationship to Primary Insured	
49a In the past have you received medical attention for the mentioned symptoms or illness? ☐ **Yes** ☐ **No**	**49b** If **YES**, please indicate the date you were last treated MM/DD/YYYY
50 Period of Hospitalization (if applicable) MM/DD/YYYY From:	To:

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 Seven Corners 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.

51 Date MM/DD/YYYY	**52** Signature (Signature of Person Suffering Illness or Injury or legally authorized representative)

Physician's Statement – To Be Completed By Physician Only

53 Name of doctor	**54** Office phone number		**55** Office fax number
56 Office mailing address	**57** City	**58** State	**59** Zip code
60 Name of patient	**61** Age		
62 Diagnosis that resulted cancellation/interruption			
63 Date symptoms first appeared or accident occurred MM/DD/YYYY	**64** Date of first treatment for listed diagnosis MM/DD/YYYY		
65 Was patient treated by someone else? ☐ **Yes** ☐ **No**	**65a** If **YES**, by whom?		**65b** If **YES**, when? MM/DD/YYYY
66 Was patient prohibited to travel due to this illness/injury? ☐ **Yes** ☐ **No**			
67 Date completed MM/DD/YYYY	**68** Physician's signature		

Documentation Requirements

69 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.	
	Airline Ticket Stub/Receipt
	Copies of canceled checks or credit card statements with an invoice from your Travel Provider showing the date of your deposit. If you seek to waive the pre-existing condition exclusion on your claim, you must submit proof of insurance purchase within 14 days of making your initial trip deposit.
	Police Report
	Statement from Hotel/Motel, Airline Carrier or Airport Facility that concerns your Cancellation/Delay. Note: Any cancellation or delay of flight must be documented by the airline.
	Car Rental Agreement
	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.
	Original purchase receipts for additional expenses
	Report from common carrier confirming delay
	Other (please describe)

Other Insurance / Authorization

70a Do you have any other travel or out-of-country medical insurance through an employer, spouse's employer, retirement plan or credit card? ☐ **Yes** ☐ **No**	**70b** If **YES**, please indicate name of insurance company
71 Plan number	**72** Credit card issuing bank

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 regarding this claim and the loss reported.

I UNDERSTAND the information obtained by use of the authorization, will be used by Seven Corners to determine eligibility for benefits under this plan. Any information obtained will not be released by Seven Corners to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I further authorize.

I KNOW that I may request to receive a copy of the Authorization. I AGREE that a photographic copy of this authorization is as valid as the original. I AGREE that this Authorization shall be valid for two and one half years from the date shown below. I UNDERSTAND that it is illegal to knowingly file a false or fraudulent claim or to knowingly help someone else file one.

73 Signature	**74** Date MM/DD/YYYY

Send this form and any accompanying documents to Seven Corners using any of the following methods:

MAIL	UPLOAD	FAX	EMAIL
Seven Corners, Inc. **Attn: Claims** PO Box 211379 Eagan, MN 55121 USA (Allow mail 7-10 days for delivery.)	Login to **My Account** and upload your documents **www.sevencorners.com/myaccount**	(+01) 317-575-2256	jhiaclaims@sevencorners.com

Call for help: Local **1.317.582.2660** or Toll-free **1.866.888.7803**