Safe Travels Claim Form

To help us process your claim quickly, please follow these guidelines:

1. Complete a separate claim form for each and for each insured person.

2. If you are submitting a claim following an illness/accident or injury, please complete Sections A, B & E in full.

3. If you are submitting a claim for a non-medical incident; trip interruption; emergency reunion; lost baggage; personal effects, please complete Sections A, (C - D as appropriate) & E.

4. If you are submitting an Accidental Death or Dismemberment claim; Coma; Seatbelt, please complete Sections A, B & E.

5. Please send this fully completed form to GBG Administrative Services with ALL original bills and requested documents relating to the claim.

All submissions MUST be received by GBG within 90 DAYS of the date of the loss or commencement of treatment.

A. Insured Information

Insured Name: (Last, First, MI):		Policy Number: Member Number: Date of Birth (mm/dd/yyyy):	
Home Country Address:	City:	State/Country:	Zip:
Phone Number:	Alternate Number:	E-mail Address:	
Correspondence Address: - place you want us to contact you via mail			
Your Home Country: (as declared on the application)	Your Destination:		
Trip Dates:	Purpose of Trip: □ Holiday □ Business □ Medical □ Other		

B. Hospital & Medical Expenses (includes prescriptions, x-rays, and physician visits)

Is the claim the result of an Accident: □ Yes □ No (if yes, please describe accident in detail):		
Is the claim the result of an Illness: □ Yes □ No (if yes, please describe symptoms):		
Date Accident/Illness Started:	Date first treated for this Accident/Illness:	Name of Physician/Facility first consulted:
Address of Treating Physician/Facility:	Providers Phone Number:	
Have you ever been treated for this illness/accident in the past: □ Yes □ No (if yes, indicate the date first treated and treatment recommended):		
Is this a claim for treatment of a unexpected recurrence of a pre-existing condition ?: □ Yes □ No		
Name, Address and Phone Number of Insured's personal family physician / medical facility where the condition was treated:		
Did your physician prohibit you from traveling by air or otherwise due to this injury/illness? □ Yes □ No (if yes. Indicate date and treatment recommended:		

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B. HOSPITAL & MEDICAL EXPENSESCONTINUED(includes prescriptions, x-rays, and physician visits):

Were you traveling to receive medical treatment? □ Yes □ No (if yes, when did the you first learn of the alternative treatment and who recommended the treatment)

If treatment was given in hospital, as an inpatient List Name, Address and Phone Number of Facility Admitted to:

Admit Date: Discharge Date: Recommended Treatment following discharge:

Was Europ Assist USA Contacted: □ Yes (If yes please give your file number _____)
□ No (if No please state why)

Are you pregnant: □ Yes □ No (if yes, indicates how many weeks):	Does the Insured have Other Medical Insurance: □ Yes □ No If so, please provide the insurance carrier details including name, address and policy number:

FOR EU CITIZENS ONLY:

Was an EHC (European Health Card) taken on this trip:
□ Yes □ No

Was the EHC card presented to the Hospital or Physician
□ Yes □ No (if no please explain)

C. CANCELLATION OR INTERRUPTION

Date Travel Arrangements Made:	Date of Initial Payment/Deposit:
Scheduled Date of Departure:	Scheduled Date of Return:
Date Trip Cancelled or Interrupted:	Place:

Please provide a detailed explanation of why the trip was Cancelled / Interrupted:

If Cancellation/Disruption involves another party- Complete Below Information:

Name of Party Involved:	Relationship to Member:

Reason for Cancellation/Interruption:

Were additional expenses incurred?: □ Yes □ No (If yes, please provide details below and send all invoices/receipts with this claim form):

1) If the trip was cancelled due to injury/illness of the Insured Person, please attach written confirmation from the General Practitioner that the Insured Person was unfit to travel.
2) If the trip was cancelled due to the injury/illness of a third party, please attach written confirmation third party's General Practitioner confirming the injury/illness.
3) Please attach documentation in support of the cancellation of the trip for any other factor not described above.

4) Please attach the original booking invoice and the cancellation invoice showing the charges incurred.

If you are claiming benefits due to the medical reasons or death of a Family Member or Traveling Companion please complete the below questions

Name of person sick/injured:	*His / Her date of birth:*	*Relationship to Member:*

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C. CANCELLATION OR INTERRUPTION CONTINUED:

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)- Admit Date: *Discharge Date:*

His/ Her Date of Death:

In the event of a fatality, a Death Certificate issued by a licensed authority must be obtained, with the original copy being submitted to GBG Administrative Services.

D. LOST BAGGAGE/PERSONAL EFFECTS INFORMATION:

Date of loss or damage:	Time:

Please provide a detailed description of how the loss/damage occurred, including the location:

Please confirm when the loss/damage was reported and to which authority (e.g., police/airline/tour operator/hotel, etc.), including complete address and reference:

Company Name (airline/hotel etc.)	Item Lost/Damaged	Amount Paid For Item	Amount of Loss (nonrefundable)	Have you received reimbursement?	Who reimbursed you?	How much was reimbursed?
		$	$			$
		$	$			$
		$	$			$
		$	$			$
		$	$			$
		$	$			$
		$	$			$
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		$	$			$
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		$	$			$

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E. 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 regarding this claim and the loss reported.

I UNDERSTAND the information obtained by use of the authorization, will be used by Trawick International/GBG Claims to determine eligibility for benefits under this plan. Any information obtained will not be released by Trawick International/GBG Claims 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. I have read and understand the Fraud Notices.

Signed Date

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.***

____ Medical Bills and Receipts

____ Airline Ticket Stub/Receipt

____ Copies of cancelled checks or credit card statements within an invoice from your Travel Provider showing the date of your deposit or purchase.

____ Police Report

____Statement from Hotel/Motel, Airline Carrier or Airport Facility which concerns: Cancellation/Interruption/Reunion. **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.

____ Death Certificate

____ Other (please describe):_____

FRAUD NOTICES:

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.

FRAUD NOTICES CONTINUED:

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 member for the purpose of defrauding or attempting to defraud the policyholder or member 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.

Send this form and any accompanying documentation to:

GBG Administrative Services
26741 Portola Pkwy Ste. 1E #527
Foothill Ranch, CA 92610
For claim status call 877-916-7920 Local: 949-916-7941