



Administered by Travel Insured International; Claims Department
P.O. Box 280568, East Hartford, CT 06128-0568
Phone: 866-890-6499, Fax: 860-256-0518
Email: claims@travelinsured.com, www.trippreserver.com

Dear Valued Customer:

We are sorry that your travel plans were disrupted. We have attached the following checklist and claim forms that you will need to complete your Trip Interruption claim submission:

- Trip Interruption Checklist
- Trip Interruption Claim Form
- Planholder/Patient Authorization Form
- Attending Physician Statement

You do not need to submit the checklist with your claim; it is designed to guide you through the submission process by outlining the documents and completed forms that you will need to submit for us to review your claim.

We understand that filing a claim can be an unsettling experience. We are here to help! Our Claims Department office hours are Monday through Friday from 8:00am to 5:30pm Eastern Time. If you have any questions, please call us at 1-866-890-6499 or 1-860-528-7663 (outside the U.S. or Canada), or email us at claims@travelinsured.com.

Please write your name and policy number on all documents and mail to:

Travel Insured International, Inc.
Attention: Claims Department
52-S Oakland Avenue
P.O. Box 280568
East Hartford, CT 06128-0568

We look forward to assisting you throughout the claims process, and we thank you for choosing Trip Preserver.

Sincerely,

Trip Preserver Claims Department



Trip Interruption Claim Required Documents Checklist

The Trip Interruption Claim Checklist can be used to submit claims related to:

- Unused pre-paid portions of your trip.
- Additional transportation costs to return home or to resume your trip.

The sections below outline the forms and supporting documentation that we will need to review your claim. The information in Section 1 must be provided for all claims. Based on the reason for the claim, you may also need to provide documentation from one of the other sections of the checklist.

Reason for Claim	Provide Documentation from:
Unused Pre-Paid Trip Expenses	Section 1
Additional Airfare and Other Expenses	Sections 1 and 2

SECTION 1 - Information Needed for All Claims

1. Claim Form

- Complete and sign *Trip Interruption Claim Form*.

2. Proof of Loss (*Why was your trip interrupted?*)

- Illness or Injury:** Provide the *Planholder/Patient Authorization Claim Form* and ask your physician to complete the *Attending Physician's Statement*.
- Death:** Provide a photocopy of Death Certificate.
- Other:** Provide documentation of event that caused your trip interruption.

3. Proof of Reservation

- Provide a photocopy of your final Rental Invoice.
- Provide a photocopy of your Rental Agreement.

4. Airline Tickets (*If applicable.*)

- Provide photocopies of the original tickets or a photocopy of the e-ticket receipt which includes ticket numbers and dates of travel.

SECTION 2 –Additional Transportation

1. Proof of Payment (*How did you pay for the additional transportation expenses?*)

- Check:** Provide photocopies of the processed checks (front and back).
- Cash:** Provide photocopies of the cash receipts.
- Credit Card:** Provide photocopies of the section of the monthly credit card statements showing all payments made for your additional travel arrangements.

2. Airline Tickets (*If applicable.*)

- Provide photocopies of the e-tickets or receipts verifying the cost of the additional airfare arrangements you purchased.



Trip Interruption Claim Required Documents Checklist

SECTION 3 –Submit Your Documentation

Please return completed forms and required documentation by mail to:

Travel Insured International, Inc.
Attention: Claims Department
52-S Oakland Avenue
P.O. Box 280568
East Hartford, CT 06128-0568

Please do not use staples, tape or paperclips. Please do not return this checklist.

If you have questions about the forms or required documentation, please call us or send us an email. Our Claim representatives are available to assist you Monday through Friday from 8:00am to 5:30pm.

Phone: (866) 890-6499 (in the U.S. and Canada)
(860) 528-7663 (outside U.S.)

Email: claims@travelinsured.com



Trip Interruption Claim Form

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Section 1 - To Be Completed by the Planholder Who is Claiming Benefits

Name of Planholder and Address	Date of Birth	Plan/Policy #
	Home Phone #	Alternate Phone #
	Check In Date	Check Out Date
Planholder's Email	Initial Trip Deposit Date	Reservation #
Name of Property Management Company	Date Incident Occurred	Date Trip Interrupted
If you are a leaseholder on a rental property please list all guests occupying the property		
Please briefly explain the circumstances of your claim:		
Do you have any other travel insurance that may provide coverage for this claim? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please identify the name of the travel insurance company:		

Section 2 - Claimed Expenses

Enter all claimed expenses in the table below. You will need to provide supporting documentation in order for the claim to be processed. See the Trip Interruption Required Documents Checklist for required documents.

Category	Amount	Definition
Additional Expenses:		
Airfare	\$	Cost of additional airline tickets
Ground Transportation	\$	Cost of additional ground transport
Unused Expenses:		
Airfare **	\$	Value of unused airline tickets
Reservation Amount	\$	Cost of rental arrangements
Total Expenses	\$	Sum of all the above expenses
Refunds	\$	Refunds received
Total Claim Amount	\$	Total expenses minus refunds

** If you are claiming an amount for unused airfare, do you plan on using the tickets within 1 year from the issue date? Yes No

Section 3 - Declaration

Any person who knowingly and with intent to injure defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable by law.

I have read the foregoing, and the above answers are true and complete according to the best of my knowledge and belief.

Signature of Planholder _____
 Date



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Planholder/Patient Authorization Claim Form

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Section 1 – Planholder Information

Name and Address of Planholder	Plan/Policy #	
	Home Phone #	Alternate Phone #
	Check In Date	Check Out Date
Planholder's Email	Initial Trip Deposit Date	Date Incident Occurred

Section 2 – Patient Information

Patient's Legal Name (First, Middle, Last)	Date of Birth	Was the patient scheduled to go on the trip? Yes <input type="checkbox"/> No <input type="checkbox"/>
Provide the name and address of patient's regular physician in his/her home country:		Physician's Phone #
		Physician's Fax #
Please list the names of any prescription medications presently taken:		
Indicate other health insurance coverage, include name, address and policy #.		
Reason for Treatment: <input type="checkbox"/> - Illness <input type="checkbox"/> - Injury *	* If injury is a result of an accident please give a detailed explanation:	
Was a motor vehicle involved? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please list the names of the involved parties, insurance carriers and policy numbers.		
Was a police report filed? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please identify the Police Department where it was filed.		

Section 3 – Authorization to obtain and disclose information in connection with a claim for benefits:

To all providers of medical or dental services or suppliers and their representatives, all insurers, medical or hospital service plans, prepaid health plans, employers, group policyholders or contract holders:

For purposes of claims administration and audit, I authorize you to furnish Travel Insured International, Inc., or its representatives performing business or legal functions, any information available about the medical history, condition and treatment of, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the policy number identified above.

I authorize Travel Insured International, Inc. to use such information and to redisclose it for the above purposes to its representatives, and to my employer, union, group contract holder and their representatives, and to any insurer, medical or hospital service plan, prepaid health plan or reinsurer. I also authorize Travel Insured International, Inc. to redisclose such information to an attending physician for treatment purposes, to governmental authorities when necessary to prevent or prosecute fraud or other illegal activities, to any person who has an authorization specifically permitting the redisclosure, and as may be permitted or required by law.

This authorization is valid for one year from the date below. I agree that a photographic copy of this authorization shall be valid as the original. I know that I have the right to ask for and receive a copy of this authorization.

Signature of Patient (Parent if patient is a minor) _____
Date



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Attending Physician Statement

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Section 1 – Planholder Information

Name of Planholder	Relationship to Patient	Plan/Policy #
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Section 2 – Patient Information (to be completed by Physician)

Patient Name (First, Middle, Last)	Diagnosis and ICD-9 Code	
What is the exact date that symptoms first appeared?	When did the patient first consult you for this condition?	
Did you advise the trip be cancelled or interrupted due to the patient's medical condition? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain why:		
Has the patient ever had the same or similar condition? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what was the date?		
Is this condition a complication of an underlying condition? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please list all dates you provided treatment for this condition.		
Was this patient referred to you by another physician? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what was the date referred?		
Name of Referring Physician	Phone #	
Was the patient hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide the name of the hospital.		
Was this an emergency room admission? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date Admitted	Date Discharged
Please note: All of the above requested information is necessary for the processing of the planholder's claim. Any omitted items will delay processing.		

Section 3 – Physician Information (to be completed by Physician)

Physician's Name	Phone #
Specialty	Fax #
Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable by law.	
I have read the foregoing, and the above answers are true and complete according to the best of my knowledge and belief.	
_____ Signature of Physician	_____ Date