

Trip Cancellation Or Interruption Claim Form

(medical reasons)

Return to: World Access
PO Box 72031
Richmond, VA 23255-2031
Fax: 1-804-673-1469

Our goal is to ensure we handle your claim courteously, promptly, and efficiently. Please take a few moments to read over and complete this form. If you have any questions, call our Claim Inquiry Department at 1-800-334-7525 anytime – we are available 24 hours a day.

Once we have received your claim form, we will email or mail a notification of receipt postcard to you. The status of your claim can be viewed at any time by visiting www.eclaimline.com/travel, clicking on the “Check Claim Status” link and entering the claim # found on the front of the postcard.

First Name: _____ Last Name: _____

Date of Birth: ____/____/____

Place of Birth: _____

Social Security Number: _____

Your Home Address: _____

City, State, Zip Code: _____

Your Mailing Address, if different: _____

Policy ID, Product ID, or Group #: _____

Home Telephone: (____) _____ Work Telephone: (____) _____

Trip Departure Date: ____/____/____ Scheduled Return Date: ____/____/____

Date Insurance was purchased: ____/____/____ Date incident occurred: ____/____/____

Names of Traveling Companions & Policy ID: _____

What was the date you called your Travel Agent or Travel Supplier and canceled your trip? ____/____/____

Please supply a brief description of the circumstances that caused your inconvenience:

Do you have other insurance? _____

Complete A or B below

____ A The following question is only if your illness/injury was the cause of the cancellation/interruption:
Your insurance requires that a licensed physician complete an examination.

What date did your doctor advise cancellation/interruption? ____/____/____

It is essential that the physician of the ill party complete the enclosed Physician Statement Form and that you return it with this claim form. This form provides us with important information for our claims records and is required to process your claim promptly.

____ B **If you canceled or interrupted your trip due to another person’s illness or injury:**

What date did this person’s doctor advise you to interrupt or cancel your trip? ____/____/____

Please provide the name, address, and phone number of the physician.

Physician’ Name: _____ Physician’s Phone Number: (____) _____

Physician’s Address: _____

If your cancellation or interruption was due to someone’s death, we require a copy of the death certificate. In some cases, we may need to request the medical records of that person.

Now that we have this information, we need to know how much money you are claiming. **Remember, your insurance premium is non-refundable!**

We need to make sure we reimburse you any money(s) you have lost and were not refunded or credited from any other source. We will subtract any published refund(s) that we believe you may be entitled to from the amount of your claim. **If you do not receive any refund(s), please have your Travel Supplier (airline, cruise line, tour operator) or your Travel Agent provide us that information in writing.** Remember, this has to come from the Travel Supplier or your Travel Agent.

If you interrupted your trip, we must have an invoice and receipts for any expenses you are claiming to determine the correct reimbursement amount. Your travel Supplier or Agent can provide an invoice.

Look at your travel documents. These could be invoices, receipts, etc. from the Travel Supplier or Agent. From those, tell us how much you paid for each part of your trip.

A. Description of Expenses	
Tour cost (please attach copy of invoice) _____	\$ _____
Airfare (please also return the original airline tickets with this form) _____	\$ _____
Other expenses (please specify) _____	\$ _____
_____	\$ _____
_____	\$ _____
B. Total Expenses _____	\$ _____
C. Subtract refunds, credits, trip or meal vouchers _____	\$ _____
D. Total amount you are claiming _____	\$ _____

Make sure for each entry above you send us proof that you paid the amount you are claiming. A copy of a canceled check, credit card statement, or receipts will usually accomplish this.

**PLEASE READ AND SIGN THIS FORM.
FAILURE TO SIGN AND DATE MAY DELAY THE REVIEW OF YOUR CLAIM.**

Any person who knowingly and with intent to injure, defraud, or deceive 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 and subject to criminal prosecution, substantial civil penalty and the stated value of the claim for each such violation.

I hereby authorize my treating physician and/or facility to furnish World Access all information including findings and treatment rendered, and copies of all hospital or medical records. This authorization is granted with the understanding that any legal rights I may have ordinarily to communications between us as privileged are hereby expressly and voluntarily waived. A copy of this authorization shall be considered as valid as the original.

By signing this claim form, I certify that the claim information above is true and correct to the best of my knowledge and belief.

Signature: _____ Date Signed: ____/____/____

Check the information your are attaching to this form:

<input type="checkbox"/> Completed Physician Statement Form	<input type="checkbox"/> e-Ticket receipt/Original Air Tickets (Electronic tickets must be printed out)
<input type="checkbox"/> Death Certificate	<input type="checkbox"/> Refund Information
<input type="checkbox"/> Receipts or expenses	<input type="checkbox"/> Proof of Loss
<input type="checkbox"/> Letter from Cruise Line Verifying Cancellation	<input type="checkbox"/> Travel Agent/Supplier Invoice
	<input type="checkbox"/> Proof of Payments