ESIS®

Travel Claim Form

IMPORTANT NOTICE: To facilitate the processing of your claim, you are required to complete sections A and B for all claim Submissions. The issue and acceptance of this form does NOT constitute an admission of liability by ESIS or waiver of its rights.

The information requested and documents mentioned in this form are a general guide. Further documents or information may be required depending on the circumstances of your claim. Note that failure to provide supporting documentation may result in delays in the processing of your claim.

Your Policy may not provide cover under every section shown in this Claim Form.

Please mail your completed Claim Form along with the items listed below to:

ESIS Specialty Claims
PO Box 6802
Scranton, PA 18505-0556

(844) 756 5571 Inside USA
(248) 368 0577 Outside USA
(248) 440 7626 Fax
ESISA&H@esis.com

Declarations

Did you remember to enclose the following? (Where applicable)

Document	Yes	NA
Travel Documents (i.e. Air Tickets and / or Boarding Pass)	☐	☐
Medical Bills (Original copy need to be submitted for Reimbursement claim)	☐	☐
Written notes from Physician on type of injury sustained / Inpatient Discharge Summary or Medical Report	☐	☐
Police Report (if involved in Road Accident)	☐	☐
Original purchase receipts and photographs (for Loss and / or Damage of personal property claim)	☐	☐
Overseas Police or relevant authorities concerned Report (for Loss of personal property and/or money claim)	☐	☐
Documents with relevant authorities concerned (for Damage of personal property claim)	☐	☐
Settlement / Reply Letter from transport service provider, hotel or travel agent (for Interruption or Cancellation claim)	☐	☐
Written confirmation issued by the transport service provider (for Baggage Delay, Flight Delay or Flight Misconnection claim)	☐	☐
Confirmation of receipt of luggage (for Luggage Delay claim)	☐	☐
Letter from the third party concerned (for Legal Liability claim)	☐	☐
Death Certificate, Post Mortem Report, Autopsy Report, Police Reports, Letter of Administration (if involves Fatalities)	☐	☐
Documents to proof occurrences of the incident and amount claimed	☐	☐

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Section A: Policyholder / Insured Person and Claimant Information

Policyholder Name: _____ Policy Number: _____

Policyholder / Insured Person Information

First Name: _____ Last Name: _____

SSN: _____

Passport Number: _____

Email Address: _____ Cell Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

County: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Employer Information of Policyholder/Insured Person

Name of Employer: _____

Occupation: _____

Employer's Address

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Work Phone: _____

Claimant Information (if different from Policyholder/Insured Person)

First Name: _____ Last Name: _____

SSN: _____

Passport Number: _____

Email Address: _____ Cell Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

County: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Relationship to Policyholder/Insured Person: _____

Employer Information of Claimant

Name of Employer: _____

Occupation: _____

Employer's Address

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Work Phone: _____

Section B: Details of Accident / Loss / Illness

Date of Accident / Loss / Illness (DD/MM/YYYY): _____

Time of Accident/Loss / Illness: _____

Place of Accident / Loss / Illness: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

County: _____

State specifically what happened: _____

_____

_____

_____

Date of Departure (DD/MM/YYYY): _____

Mode of Departure: _____

Place of Departure (State/Province and Country): _____

Departure City: _____ Departure State/Province: _____

Departure Country: _____

Airport Name (if applicable): _____

Period of Travel (DD/MM/YYYY) From: _____ To: _____

Arrival Country(s): _____

Purpose of Trip: ☐ Leisure ☐ Business ☐ Others (Please Specify): _____

When as the Accident / Loss Discovered: _____

Who Discovered the Accident / Loss: _____

Witness Information

Were there witnesses to the accident? ☐ Yes ☐ No

If **Yes**, please provide the following details:

Witness 1

First Name: _____ Last Name: _____

Phone Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Witness 2

First Name: _____ Last Name: _____

Phone Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP _____ Country: _____

Section C: Personal Accident / Illness – Medical and Additional Expenses

Please note:

1) Personal Accident - please enclose Police Report (if any), Detailed Medical Report, Medical Certificate.
2) Medical, Dental or Post Journey Medical Expenses – please enclose Original Detailed Pre-Medical / Final Hospitalization/Post-Medical Bills, Inpatient Discharge Summary, Detailed Medical Report / Memo from Attending Physician on the type of illness or injury sustained.
3) Emergency Travel Expenses – please enclose Certified True Copy of Death Certificate and Proof of Relationship or written advice of attending Physician indicating the need to travel to or remain with the Insured Person, with Original Bills and Receipts of travel and accommodation expenses incurred.
4) Accidental Death – please enclose Police Report, Certified True Copy of Death Certificate, Autopsy Report, Toxicological Report.

1. Was it due to illness? ☐Yes ☐No

If **Yes**, please specify type of illness

_____

When did first symptoms appear? (DD/MM/YYYY): _____

When did you receive medical attention for this condition? (MM/DD/YYYY): _____

Please provide Name & Address of Attending Physician

Physician Name: _____

Physician Specialty: _____

Phone Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

2. Have you ever had this or similar condition? ☐ Yes ☐ No

If **Yes**, please provide details

_____

_____

_____

_____

Is this a Routine Check-up? ☐ Yes ☐ No

If **Yes**, please provide details, dates and name and address of the Attending Physician:

_____

_____

Physician Name: _____

Physician Specialty: _____

Phone Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

3. Was it due to an Accident? ☐ Yes ☐ No

If **Yes**, please provide the Date of Accident (DD/MM/YYYY): _____

Describe how the accident occurred: _____

_____

_____

_____

Where did the Accident/Illness Occur?

Name of Event/Location/Facility: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Amount Paid by You: _____

Amount Recovered From Other Sources: _____

Please provide details of any settlement: _____

_____

_____

_____

Amount Claimed: _____

Section D: Cancellation / Interruption

Please note:

1) Please enclose documentary proof of relevant expenses incurred as a result of this trip cancellation or interruption, original trip booking and invoice, Death Certificate, Medical Report and/or Written Memo from Attending Physician to cancel trip, Proof of Relationship, Travel Agents' confirmation of the amount of refund.
2) Original Invoice or Receipt of charges incurred in amending or purchasing additional air ticket (for Trip Interruption).

When, where and with which Provider/Agency was the travel booked?

_____

_____

_____

Intended Departure Date (DD/MM./YYYY): _____

Please State Reason for Cancellation/Interruption: _____

_____

_____

_____

Date you became aware of the need to cancel / interrupt your trip (DD/MM/YYYY): _____

Date cancelled / interrupted (DD/MM/YYYY): _____

Amount paid by you: _____

Amount recovered from other sources: _____

Please provide details of settlement): _____

_____

_____

_____

Amount claimed: _____

Section E: Personal Effects

Please enclose:

1) Police Report or report issued by responsible Hotel Management or Provider/Agency evidencing such losses,
2) Property Irregularity Report for losses in Provider/Agency custody,
3) Original Purchases Bills,
4) Photographs of damaged items,
5) Original Repairs Bills damaged items.

If the responsible Hotel Management or Provider/Agency has made compensation for the damaged or lost items, please request them to issue a note or letter certifying the compensation issued or will be issued to you.

Details of Amount Claimed (Please use supplementary sheet if necessary)				
Description of Item	When and Where Purchased	Original Purchase Price	Amount Recovered From Other Sources (Please provide details of settlement)	Amount Claiming

Any actions taken in attempt to recover your property? ☐ Yes ☐ No

If **Yes** , please provide details on the actions taken. If **No**, please provide details for not attempting recovery.

_____

_____

_____

_____

Section F: Personal Money / Travel Documents

Please enclose:
1) Police Report or report issued by responsible Hotel Management or Provider/Agency evidencing such losses,
2) Original Receipts for replacement of travel documents.

Amount Paid by You: _____

Amount Recovered From Other Sources (Please provide details of settlement): _____

_____

_____

_____

Amount Claimed: _____

Section G: Flight Delay / Missed Connection / Flight Diversion / Baggage Delay / Flight Overbooking

Please Note:

1) Flight Delay / Missed Connection / Diversion – enclose the original itinerary, boarding pass showing the actual take off time and date, written confirmation from carrier/airline or their agents specifying reasons for and hours of delay/diversion.

2) Baggage Delay – to enclose original itinerary, written confirmation from carrier/airline or their agents specifying reason and the number of hours of baggage delay, Property Irregularity Report, Acknowledgement Receipt of baggage received.

Reason for claim:

☐ Travel Delay ☐ Missed connection ☐ Flight Diversion ☐ Baggage Delay ☐ Flight Overbooking

Details of Flight Itinerary	
Original Travel Details	Actual Travel Details
Travel Delay / Flight Diversion	
Transport / Flight No.: _____	Transport / Flight No.: _____
Scheduled Departure Date, Time and Place: _____	Actual /Rescheduled Departure Date, Time and Place: _____
Scheduled Arrival Date, Time and Place: _____	Actual / Rescheduled Arrival Date, Time and Place: _____

Length of delay:

_____

Reason provided by carrier for cause of delay (Please provide documentary proof from carrier):

_____

_____

_____

Travel Missed Connection

Actual arrival time of incoming conmnection transport resulting in your missed connection:

_____

Scheduled date and time of connecting flight:

_____

Transport / Flight No.:

_____

Nexts date and time of connecting flight:

_____

Transport / Flight No.:

_____

Lengthof delay:

_____

Baggage Delay

Arrival Date, Time and Place: _____

Date, Time and Place you received your baggage:

_____

Length of Delay:_____

Expenses Incurred By You: *(Please state date and item(s). This may not be applicable, depending on the coverage under the policy that you have.)*

_____

_____

Amount Recovered From Other Sources (Please provide details of settlement): _____

_____

_____

Amount Claimed: _____

Section H: Personal Liability

Please note: In no circumstances should the issue of legal liability be admitted to any third party claimant(s). Please enclose letters / writs / summons from third party / police / court.

Date, Time and Location of Incident	
Please describe what happened (Please attach photos, if any)	
Was the accident due to carelessness or negligence on your part? ☐ Yes ☐ No If **Yes**, please elaborate.	
Have you in any way admitted liability? ☐ Yes ☐ No	

If **Yes**, please elaborate.		
Name and Address of witness to the accident (if any)		
To which Police Officer and / or Police Station (if any) did you report the occurrence?		
Names and addresses of the other party(s)		
Was a personal injury sustained by any person other than you? If so, please additional information	Name and Age	Nature of Injury
Extent of damage to property belonging to other party(ies)	Property	Nature of Damage
Has a claim been made upon you? ☐ Yes ☐ No If **Yes**, please elaborate and specify ther amount of the claim (if known).		
Please give any additional information which you consider would help the Insurer in dealing with any claim that may be made against you.		

Section I: Others (Please specify details of any claim other than Section B to G

Name of Police Station, Carrier / Airline or other authorities where Report lodged (if applicable):

Detail of Claim (Please use supplementary sheet if necessary):

Amount Claimed: _____

Do you have legal representation? ☐Yes ☐No

If **Yes**, please provide representative details below.

Name of Firm: _____

First Name: _____ Last Name: _____

Title: _____

Email Address: _____ Phone Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Phone #: _____

Section J: Any Other Insurance / Claims

Are there any other insurance policies in force that cover you in respect to this event? ☐Yes ☐No

If **Yes**, please provide representative details below.

Insurance Company Name: _____

Phone Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

Policy Number / Account Number: _____

Are you filing a claim under the policy listed above? ☐Yes ☐No

If **Yes**, please provide Claim Reference Number: _____

Are you making a claim against any other party in respect of this event? ☐Yes ☐No

If **Yes** , please specify below (*Please use supplementary sheet if more than one applies*):

First Name: _____ Last Name: _____

Email Address: _____ Phone Number: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

County: _____

Section K: Claims History

1. Have you or the Insured Person previously made claim(s) under a travel, medical or accident policy?
   ☐Yes ☐No

2. Have you or the Insured Person made claims with similar occurrences or involving similar items?
   ☐Yes ☐No

If the answer is **Yes** to any of these, please provide details below:
(Please use supplementary sheet if necessary)

Date of Claim (DD/MM/YYYY): _____

Reason for Claim: _____

Insurance Company Name: _____

Phone Number: _____

Email Address: _____

Street Address: _____

Address Line2: _____

City: _____ State: _____

ZIP: _____ Country: _____

County: _____

Policy Number / Account Number: _____

Claim Reference Number: _____

By signing the below I hereby certify that the above information is true and correct to the best of my knowledge and belief

Authorization and Assignment of Benefits

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, 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 the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I *agree* that a photographic copy of this Authorization shall be as valid as the original.

I understand that I or my authorized representative may request a copy of this authorization.

I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative:

_____

Dated: _____

Fraud Warning: Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalized fraud stated. We have adopted the fraud warning language prescribed by the District of Columbia as its standard fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications and enrollment forms.

District of Columbia Generic 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.

The following states have required us to use state specific language as follows:

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.

Florida
Any person who knowingly and with intent in 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.

New York
Any person who knowingly and with 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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Oklahoma
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes ant claim for the process of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania:
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 and subjects such person to criminal and civil penalties.

Maryland/Oregon
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 may be guilty of insurance fraud.

Virginia
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 may have violated state law.