IMG® Global Work & Travel Claim Form



Trip Cancellation / Curtailment

For All Claims

The following documentation is required to begin processing your claim:
☐ The fully completed claim form, signed and dated
☐ The complete trip itinerary & a copy of itemized invoice showing amount paid for trip
Examples: e-ticket or paper ticket, hotel charges, service fees and other accommodation expenses
□ Proof of payment for the trip
Examples: credit card statement, cancelled check, common carrier and travel supplier receipts
 Statement from common carrier, travel supplier, or travel agency indicating if any refund, reimbursement, credit, and/ or voucher was issued. If no refund, reimbursement, credit, or voucher was issued, a copy of the Cancellation terms and conditions must be provided to verify you are not entitled to reimbursement or credits from any other source Written proof from travel supplier verifying reservation was cancelled
For Medical Cancellation / Curtailment
If trip was cancelled or curtailed due to sickness, injury, or death, include medical documentation including but not limited to:
☐ Attending physician's statement (completed by the treating physician)
□ Copy of death certificate (if applicable)
☐ Proof of relationship (if cancellation is due to the illness, injury or death of a family member)
For Other Reasons
If the trip was cancelled or curtailed due to other causes, include the additional documents to show proof of loss due to any of the "Other Covered Reasons" identified in the insurance contract:
\square Fire marshal or insurance company report attesting to the fact the primary residence is uninhabitable
Travel Delay
The following documentation is required to begin processing your claim:
 A copy of the complete trip itinerary including all transportation details and ticket information
 A copy of the complete altered itinerary issued by the travel supplier or common carrier due to the delay, including reservation numbers
 Documentation from the travel supplier and common carrier (airline, cruise line, etc.) indicating the reason and length of the delay
Missed Departure and Journey Disruption
The following documentation is required to begin processing your claim:
Missed Departure
☐ A copy of the complete trip itinerary including all transportation details and ticket information
 A copy of the complete altered itinerary issued by the travel supplier or common carrier due to the delay, including reservation numbers
□ Documentation from the travel supplier and common carrier (airline, cruise line, etc.) indicating the reason and length of the delay
 Documentation verifying any refunds, reimbursement, credits or vouchers issued by the travel supplier and common carrier following the delay
☐ Itemized receipts for additional expenses incurred due to the delay
☐ Proof of vehicle breakdown, such as tow service receipt or repair estimate
☐ Documentation of road traffic accident
Journey Disruption
 Local medical epidemic or directive from a qualified national or local authority directly affecting the area where the insured Person is traveling
☐ Letter from transportation authority attesting to hijacking report
Documentation verifying terrorist incident (i.e., civil unrest and war) within 30 days of departure date in the city you were

scheduled to travel during the trip or proof due to Natural Disaster	f of mandatory evacuation by local governme	ent authority at your trip destination
☐ Fire marshal or insurance company report a	attesting to the fact the Member/Insured's pri	mary residence is uninhabitable
☐ Proof of hurricane warning issued by Nation	nal Hurricane Center at the trip destination w	ithin 24 hours of your scheduled trip
 Documentation from travel supplier outling mechanical breakdown or natural disaster 	ning the reason and timeframe for cessation	n of services due to weather, strike
$\ \square$ Documentation verifying insolvency of trav	el supplier led to cessation of travel services	
Baggage: Lost, Stolen or Delayed		
The following documentation is required to begin	n processing your claim	
☐ Travel Itinerary: A copy of the original itiner	ary reflecting the ticket number(s), date and	time(s) of the trip
☐ Refund: A copy of all documents that reflec	t amounts paid to you for the delay/loss	
☐ Items: Provide a detailed list of the items lo	st, stolen, or damaged in the appropriate sec	tion of this form
	ased resulting from delay. Original receipts ip must be submitted if original receipts are n	
Incident Report: An irregularity report, incident	dent report, or a copy of the initial loss report	filed with the Common Carrier.
☐ Police Report: A copy of the police report is	required for items stolen	
 Settlement Statement: A copy of the finali home insurance, credit card, etc.) that received 	•	e.g. airline, cruise line, tour operator
☐ Damage Baggage Verification: A repair est documentation must be on entity's stationed	timate or documentation from the entity mery	aking repairs. The repair estimate
PRIMARY CLAIMANT INFORMATION		
Insured's Name (Last, First, Middle):	Policy Number:	
Mailing Address:	1	
Email Address:	Home Telephone Number	Work Telephone Number

PART 1. GENERAL INFORMA	TION					
1. Full Name of Claimant: (List all claimants. Attach additional sl	heets if necessary)			Date of Birth (dd, mm, yyyy):		
Policy Number:		Relationship to Insured:				
2. Full Name of Claimant:				Date of Birth (dd, mm, yyyy):		
Policy Number:			Relationship to Insured:			
3. Full Name of Claimant:				Date of Birth (dd, mm, yyyy):		
Policy Number:			Relationship to Insured:	Relationship to Insured:		
4. Full Name of Claimant:				Date of Birth (dd, mm, yyyy):		
Policy Number:			Relationship to Insured:			
Name of Travel Supplier (e.g. Cruise Line	e, Airline, etc.) :		1			
Travel Agency's Full Name:		Travel Agent's Na	ime:	Telephone Number (with area code):		
Travel Agency's Mailing Address:				Email Address:		
Initial Deposit Date Paid for Trip (dd, mm, yyyy):	Final Payment Date (dd, mm, yyyy):	Scheduled Departure Date (dd, mm, yyyy):	Schedule Return Date (dd, mm, yyyy):	Actual Return Date (dd, mm, yyyy):		
Departure City:			Destination (City, Country or State):			
Please check box for benefits requested: Trip Cancellation Trip Curtailment If the cancellation and/or interruption/curtailment is due to sickness, injury, or death, please complete the entire claim form If the cancellation and/or interruption/curtailment is due to a non-medical reason(s), please complete Parts 2 and 4						
PART 2. EXPLANATION OF L	LOSS					
Describe in detail what occurred:						
Date Trip Cancelled/Curtailed (dd, mm, yyyy):	Total paid for trip prior to not include travel insura		Total paid per insured prior	to cancellation (US\$):		
Total paid for original airfare, per insured (include only if unused airfare is part of the loss claimed): Did you receive a refund, reimbursement, voucher, or credit from the Travel Agent, common carrier, or travel supplier? Yes No		If Yes, please list amount refunded/credited (US\$):				
Additional losses claimed due	e to Cancellation/Cur	tailment:				
Type of Expense incurred (hotel, tra	ansportation, new tickets	s):	Date Incurred (dd, mm, yyyy):	Amount (US\$):		
1				_		
2 3				_		
Please use a separate sheet of pape is required for all losses claimed. Clai	r for any additional expen	nses. Proof of paym		_		
	<u> </u>		of Cancellation/Curtailment Clair	n:		

PART 3. MEDICAL INFORMATION - Co	omplete for Cancellation/Curtailment	due to Sickness, Injury, o	r Death.
Patient's Name:	Relationship to Insured:	Date Symptoms First No (dd, mm, yyyy):	oticed
Nature of Illness:		Date of First Consultation (dd, mm, yyyy):	on
Describe onset, diagnosis and treatment:			
For Injury, describe Injury: Date of First Consultation (dd, mm, yyyy):		Date of First Consultation (dd, mm, yyyy):	on
How and where did the accident occur:			
If hospitalized, hospital name, website and ad	dress:	Dates of Confinement (c)	dd, mm, yyyy): To:
Name and Address of Treating Physician:		Telephone Number (with area code): Fax Number (with area code):	
PART 4. OTHER COVERAGE		(war area code).	
Do you have any other insurance or coverage	related to the loss (e.g. medical, travel, etc.)?		☐ Yes ☐ No
Do you have any travel other insurance covera	age (i.e. through credit card used to purchase items)?		☐ Yes ☐ No
Did you report the loss to any other insurance	company?		☐ Yes ☐ No
If Yes, which company:			
Name of Company:	Policy/Certificate Number:	Telephone Number	Website:
1			
Address:			
3			
Address:			
(Please attach a separate sheet if necessary)			
PART 5. CERTIFICATE OF MEDICAL C	CONDITION/MEDICAL PROVIDER'S STA		
Patient's Name:		Date of Birth (dd, mm, yyyy):	
Insured's Name:		Patient's Relationship to Insi	ured:
Policy Number: Policy Purchase Date(dd, mm, yyyy):			уууу):
ATTENDING PHYSICIAN'S STATEMENT.	MUST BE COMPLETED AND SIGNED	BY THE PHYSICIAN.	
	ng Cancellation/Curtailment (Please be specific):		

3. When did the patient first consult you for this condition (dd, mm, yyyy)?				
4. If patient was referred from an	nother provider, name of provider, ad	dress and telep	hone number (with area code):
5. Name, address, and telephone	e number of other medical personne	l involved:		
	on, injury, illness, or sickness that wo ate when patient was determined no			trip?
7. List all dates of treatment and	services for this condition			
Date of Services (dd, mm, yyyy):	Describe the Condition/Treatment:			
(Please attach a separate sheet if necessary)				
8. Has the patient been hospitali	ized for this condition or related cond	dition(s)?	Yes 🔲 No	
If Yes, date of first admission (d	d, mm, yyyy): Date o	of discharge (dd, i	тт, уууу):	
9. On what date did this condition	on first prevent or restrict the patient	from traveling ((dd, mm, yyyy)?	
10. On what date would the patie	ent not be restricted and medically fit t	o travel (dd, mm, y	ууу)?	
11. Did you advise the insured to	cancel travel plans prior to departu	re or return hom	ne early a resul	t of the sickness or injury?
☐ Yes ☐ No If Yes, on what date (dd, mm, yyyy)? Please explain:				
If No, on what date was the i	nsured prevented from participating	in the trip (dd, mi	m, yyyy)?	
12. If condition was related to pregnancy, date of conception (dd, mm, yyyy)? Expected Delivery Date (dd, mm, yyyy)?				
13. Was this Sickness/Injury the	sole cause of the patient's medically i	mposed restrict	tions? Yes	No No
If No, please explain:				
Additional Physician comments:				
Signature of Physician: Date Co		Date Completed (dd, mm, yyyy):		
Name of Physician:		Telephone Number (with area code):		
Address of Physician:				
Fav Number				
Taxpayer ID Number: (with area code):				
PART 6. PAYMENT DETAILS- TO PRIMARY INSURED				
Account Holder's Name:				
Bank Name:				
ank Address: City: Country:				
Currency of Reimbursement: Bank 9 digit ABA Number - U.S. Banks:				
	Bank 8 or 11 digit SWIFT Code - Non- U.S. Banks: SORT code:			
Bank account number: Bank IBAN:				
Intermediary Bank Details (If Applicable):				
Name of Intermediary Bank:				
Intermediary Bank SWIFT Code:		Intermediary	y Bank Account	t Number:

AUTHORIZATION

The undersigned understands a valid authorization is required for any use or disclosure of PHI not required or otherwise permitted without authorization by applicable privacy and confidentiality laws. The undersigned authorizes any health plan, health care professional, MIB, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency, employer, benefit plan, or any other organization or person that has provided care, advice, diagnosis, payment, treatment, or services to the insured or on the insured's behalf, has any records or knowledge of the insured's health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the insured, and any non-medical information about the insured, to disclose the insured's entire medical record, file, history, medications, and any other information concerning the insured and to give any and all such information to the insured's agent of record and authorized representatives of the insurer, IMG, and their affiliates, and subsidiaries. This information will be used to evaluate claims for benefits. Individuals have the right to refuse to sign the authorization without negative consequences to treatment or plan enrollment, except IMG will not be able to administer claims, determine benefit eligibility, or issue payments. The authorization is valid for the term of the insurance contract or plan under which a claim has been submitted. The undersigned understands that the insured has the right to receive a copy of this authorization upon request and revoke the authorization at any time in a written communication to IMG. A copy of this shall be as valid as the original. The undersigned acknowledges and understands that we will handle any information we receive as a result of this authorization according to our Privacy Policy, which is available to review online.

The undersigned represents and warrants information or documents provided to IMG by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees: 1) any insurance coverage or benefit is contingent upon any statement made to IMG as being complete and correct, and 2) benefits under any contract will be paid only if IMG decides the applicant is entitled to them.

Any person who knowingly presents a false or faudulent claim for payment of a loss of 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.

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** ATTENTION: IF YOU ARE CLAIMING AIRLINE TICKETS, PLEASE COMPLETE THE SECTION BELOW.** Your airline tickets may have value for up to one year from the original scheduled travel date. Please indicate below whether you will be exchanging your ticket for another trip. Please note: Your signature on this agreement is not a guarantee of payment. All final claim determinations are subject to eligibility and the terms of the policy.		
$\underline{\hspace{0.5cm}} I (We) will not be using our airline ticket (s). (Please include a copy of your electronic ticket confirmation (s) which includes your ticket number (s).$		
I (We) will be exchanging our airline ticket(s) for future travel. (Please submit documentation of the cost you incurred or will incur to exchange your ticket(s).)		
Signature of Insured/Claimant:	Date (dd, mm, yyyy):	
Signature of Insured/Claimant:	Date (dd, mm, yyyy):	
Signature of Insured/Claimant:	Date (dd, mm, yyyy):	
Signature of Insured/Claimant:	Date (dd, mm, yyyy):	



Send by one of the following secure methods:
Secure Message Center: www.imglobal.com/secure-message-center
Encrypted Email: insurance@imglobal.com

Fax: +1.317.655.4505

Mail: International Medical Group, Inc., Claims Department, P.O. Box 9162, Farmington Hills, MI 48333
For Other Inquiries, Call: +1.317.655.4500