



AXIS Travel Insurance Accident & Sickness Claim Form & Claimant's Statement

CLAIMANT'S INFORMATION:

POLICY NUMBER: _____

Insured's Name: _____ Date of Birth: _____

Home Phone #: (_____) _____ Cell #: (_____) _____

Email Address: _____ Work Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip Code: _____

Please advise if you wish to be contacted via e-mail or regular mail: _____

TRAVEL INFORMATION:

Date Travel Arrangements were made: _____

Date of initial payment deposit: _____

Scheduled Date of Departure: _____

Scheduled Date of Return: _____

OTHER COVERAGE / AUTHORIZATION:

Do you have any other type of coverage for this loss? _____

If so, please provide the Company Name and Address: _____

Type of Policy: _____

Contact: _____

Phone: (_____) _____

Have you filed a claim with their office at this time? : Yes _____ No _____

If yes, please note their response: _____

If not, why not: _____

ILLNESS/ACCIDENT STATEMENT:

Name of person having sickness or injury: _____ His / Her date of birth: _

Date Sickness or Injury began: _____

Date First Treated: _____

Nature of Sickness or Injury (If Injury, describe accident, including date and place): _____

Period of hospitalization: From: ____/____/____

To: ____/____/____

Date Ended: ____/____/____

Was there an accident report for this incident? _____ If Yes, please provide a copy.

Was there any previous treatment for this condition? _____ If Yes, please names of physician and dates of treatment:

EXPENSES CLAIMED:

Please provide supporting documentation of the expenses you are claiming in addition to this claim form

Name of Provider	Date Incurred	Amount of Bill	Amount Paid by Other Insurance	Amount Claimed

TOTAL AMOUNT CLAIMED \$_____

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.

- ☐ Copies of itemized bills and/or statement from medical providers for services rendered in connection with your claim. These bills and/or statements must include the date of service, the service rendered, the charge for each service, and the diagnosis
- ☐ If you have other insurance, we need the final disposition from the primary insurer listing payment or denial of your claim with them (Explanation of Benefit or "EOB").
- ☐ Copies of the front and back of your cancelled checks and/or your credit card statements showing your payments for the trip; and a copy of your trip invoice.
- ☐ Airline Ticket Stub/Receipt (if applicable)
- ☐ Copies of your credit card statements and/or cancelled checks showing your payment for the medical service submitted
- ☐ If medical expenses were incurred abroad, attach copies of your passport pages which identify you as the traveler and document your entrance into and exit from the country or countries where medical services were received

Authorization For Release of Medical Information – To be Completed by Patient

In order to process a claim for benefits, I **AUTHORIZE** any physician, hospital, or other Medical Provider to release to the Travel Insurance Claims Administrator, or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed two and one-half years from the date signed. I understand I have a right to receive a copy of this authorization.

Date: _____

Signature: _____

(Signature of Person Suffering Illness or Injury or legally authorized representative)

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 in this document.

Signed

Date

MAILING INSTRUCTIONS:

Send this form and any accompanying documentation to:

**Attn: Travel Insurance Claims
on behalf of AXIS Insurance Company**

P.O. Box 26222
Tampa, FL 33623
Or

E-mail your information to:
AXISTravClaims@cbpinsure.com

Fax: 800-560-6340
Call Toll Free: 888-562-0439
Dial Direct: 727-266-0247

CONSENT TO RECEIVE ALL COMMUNICATIONS ELECTRONICALLY

Please be advised, our preferred method of communication with you is electronically by email. Use of email helps us provide better and faster service. Please provide your consent to this in the area below. We will keep this on file with your claim.

EXPRESSED CONSENT TO RECEIVE ALL COMMUNICATIONS ELECTRONICALLY:

I AGREE TO RECEIVE ALL MAILINGS AND COMMUNICATIONS ELECTRONICALLY.

I HAVE READ AND AGREE TO THE [TERMS AND CONDITIONS](#) OF THE ELECTRONIC DELIVERY*

I ACCEPT ____ (please write in YES OR NO)

Please confirm the preferred Email address in clear print below:

ENTER Email Address Here:

***CLICK THE TERMS AND CONDITIONS ABOVE TO REVIEW ONLINE,
OR DOWNLOAD A COPY BY TYPING THE BELOW URL INTO YOUR INTERNET BROWSER:**

<http://policydocuments.tpaproducts.com/EDOD/consent.pdf>

Important Notice

- ❖ ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island, and 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.
- ❖ ***For Residents of Alabama:*** 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 restitution fines and confinement in prison, or any combination thereof.
- ❖ ***For residents of California:*** For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- ❖ ***For residents of 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 claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant regarding a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- ❖ ***For residents of the 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.
- ❖ ***For residents of 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.
- ❖ ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
- ❖ ***For residents of Maine, Tennessee, and Washington:*** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
- ❖ ***For residents of Maryland:*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ❖ ***For residents of 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 RSA 638:20.
- ❖ ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- ❖ ***For residents of 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.
- ❖ ***For residents of 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.
- ❖ ***For residents of 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.
- ❖ ***For residents of 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.

- ❖ ***For residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.
- ❖ ***For residents of 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, with is a crime and subjects such person to criminal and civil penalties.
- ❖ ***For residents of 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.
- ❖ ***For residents of Virginia:*** Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application, or files a false or deceptive statement, may have violated state law.