

Claims Department: Executive Plaza IV, 11350 McCormick Road, Suite 102, Hunt Valley, MD 21031
Phone No: 1-844-827-9994 | Fax: 1-443-279-2901 | Email: claims@archinsurancesolutions.com

Trip Cancellation Claim Instructions

The Trip Cancellation Claim Form can be used to file claims for:

- Cancellation of an entire trip
- Single occupancy upgrade

Please complete and sign the Trip Cancellation Claim Form in full and return it with the specific documentation noted for your claim.

For all claims, submit:

- Copy of your travel itinerary
- Proof of all claimed expenses
- Documentation to support non-refundable funds, or refunds/adjustments/credits provided or denied
- If you did not receive any refunds, adjustments or credits, provide a copy of the trip cancellation policy or a letter from the tour operator stating that no refunds, adjustments, or credits were available;
- Airfare cancellation confirmation, as received from your airline
- Proof of loss:
 - Illness or Injury - An Attending Physician's Statement fully completed by the patient's treating physician;
 - Death - A copy of the Death Certificate;
 - Other - Appropriate documentation showing the reason that you cancelled your trip.

If you are filing a claim under the **Optional Cancel for Any Reason Benefit**, submit a letter from your travel provider or other documentation showing the date you cancelled your trip.

If you are filing a claim under the **Optional Cancel for Work Reason Benefit**, submit a letter on company letterhead from an officer of the company confirming reason for cancellation.

Your claim should be submitted to the address at the top of these instructions.

Claims Department: Executive Plaza IV, 11350 McCormick Road, Suite 102, Hunt Valley, MD 21031
Phone No: 1-844-827-9994 | **Fax:** 1-443-279-2901 | **Email:** claims@archinsurancesolutions.com

Section 1 - Information about Insured

To be completed by the Insured Claiming Benefits			
Name of Claimant / Insured	Policy No.	Phone No. ()	
Address			
Email Address	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth
Travel Supplier / Tour Operator			
Traveling Companion(s)	Relationship	Trip Departure Date	Trip Return Date
_____	_____	Initial Trip Deposit Date	
_____	_____	Trip Cancellation Date	
_____	_____		
Do you have other travel or other insurance that may provide coverage for this claim? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If so, has claim been submitted to the other company? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name, Address & Phone No. of the other insurance company	Type of Claim		Reason for Cancellation
_____	___Trip Cancellation		___Illness ___Other
_____	___Occupancy Upgrade		___Injury
_____	___Postponement of Departure Date		Date Incident Occurred _____
_____			Date of Injury _____
Policy No.			Onset Date of Illness _____
Briefly explain the circumstances of your claim:			

If condition was the result of an accident, please provide a detailed explanation:			

Was a motor vehicle involved? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, please list the name of the involved parties, their insurance carriers and policy numbers			

Was a police or accident report filed? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, submit a copy of the police or accident report			

Claims Department: Executive Plaza IV, 11350 McCormick Road, Suite 102, Hunt Valley, MD 21031
Phone No: 1-844-827-9994 | **Fax:** 1-443-279-2901 | **Email:** claims@archinsurancesolutions.com

Section 2 - Claimed Expenses

Enter the total of 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 Cancellation Claim Instructions for required documents.

Claimed Expenses	
Category	Amount
Airfare Expenses	\$ _____
Cruise Expense	\$ _____
Tour Expense	\$ _____
Local Transportation Expense	\$ _____
Hotel Expense	\$ _____
Occupancy Upgrade	\$ _____
Other	\$ _____
Please Specify: _____	
Total Expenses	\$ _____
Refunds/Credits Received	\$ _____
Claimed Expenses	\$ _____

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement 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 Claimant

Date

Authorization to Disclose Information

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Arch insurance Company, or its authorized representative. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past.

To any insurance company, any travel organization or agency, airline carrier, cruise line, your operator, rental agency, hotel, motel, or similar entity providing lodging on a rental / lease basis or any other person who may have knowledge regarding this claim: I authorize the release any information requested regarding this claim and the loss reported.

The company will use this information to determine if any claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigation or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization.

I certify that the information given by me in support of my claim is true and correct. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution or insurance fraud.

Patient's or Authorized Representative's Signature

Date

If Authorized Representative, Relationship to Patient

or Legal Designation

Claims Department: Executive Plaza IV, 11350 McCormick Road, Suite 102, Hunt Valley, MD 21031
Phone No: 1-844-827-9994 | **Fax:** 1-443-279-2901 | **Email:** claims@archinsurancesolutions.com

Section 1: To be completed by claimant/insured

About the Claimant

Name of Claimant/Insured		Claim Number
Address (street, city, state, zip)		
Date of Birth	Trip Departure Date	Policy Date

About the Patient - Complete only if different from Insured

Name of Patient		Date of Birth
Was patient traveling with insured?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Relationship of Patient to Insured

Authorization to Disclose Information

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Arch insurance Company, or it's authorized representative. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past.

The company will use this information to determine if any claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigation or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization.

I certify that the information given by me in support of my claim is true and correct. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution or insurance fraud.

Patient's or Authorized Representative's Signature	If Authorized Representative, Relationship to Patient or Legal Designation	Date
--	--	------

For COVID-19 Related Treatment Proceed Directly To Section 3

Section 2: To be completed by physician

About the Diagnosis and Treatment (for non-COVID-19 related claims)

Diagnosis / ICD Code (primary diagnosis)	
Diagnosis / ICD Code (secondary diagnosis)	
Date symptoms first appeared	Date patient first consulted you for this condition
Has the patient ever had this condition before? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, prior dates of treatment?
Is this condition an exacerbation or a complication of an existing condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when did the condition worsen?
If the patient was referred from or to another physician, name and phone number of that physician	
Dates of medical visits as they relate to the condition causing the trip cancellation/interruption. Date(s) of visit	Was the patient seen for a physical exam? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the patient hospitalized or have they been in the past 12 months for this condition or related conditions ? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, Name & Location of Hospital	
Dates of Hospitalization	

Claims Department: Executive Plaza IV, 11350 McCormick Road, Suite 102, Hunt Valley, MD 21031
Phone No: 1-844-827-9994 | **Fax:** 1-443-279-2901 | **Email:** claims@archinsurancesolutions.com

Section 2, continued: To be completed by physician

About the Medical Condition as it relates to Travel

On what date was the Patient disabled and unable to travel?	
How long will the patient be unable to travel?	
Date you advised patient to cancel trip:	
If the patient was non-traveler, did you advise the Traveler to cancel or interrupt the trip due to the non-traveler's medical condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please explain:	If no, on what date was it reasonable for the patient/insured to cancel/interrupt their trip?
Date you advised Traveler to cancel trip:	

Section 3: To be completed by physician for COVID-19 positive patient

About the Diagnosis and Treatment of Your Patient (for COVID-19 related claims)

Diagnosis / ICD Code (primary diagnosis)	
Diagnosis / ICD Code (secondary diagnosis)	
Is patient symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe all symptoms:
Date patient first consulted you for this condition	Was the first consult in person or via Teledoc? <input type="checkbox"/> In Person <input type="checkbox"/> Teledoc
Date(s) of positive COVID test(s) and type of test(s):	
Provide all dates of medical visits as they relate to the condition causing the trip cancellation/interruption. Date(s) of visit	
Was the patient hospitalized for COVID-19 or related conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, provide the Name & Location of Hospital	
Dates of Hospitalization	

About the Medical Condition as it relates to Travel

Were your patient's COVID symptoms so disabling that they are unable to travel on date of departure? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain in detail the reasons for restrictions that would prevent your patient's travel on date of departure.
Please list the date you advised patient to cancel the trip due to the above stated reasons.
If your patient was not scheduled to travel with the Claimant, did you advise the Claimant to cancel or interrupt the trip due to your patient's medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain why you so advised:
Date you so advised the Claimant to cancel trip:

Claims Department: Executive Plaza IV, 11350 McCormick Road, Suite 102, Hunt Valley, MD 21031
Phone No: 1-844-827-9994 | **Fax:** 1-443-279-2901 | **Email:** claims@archinsurancesolutions.com

Physician Information and Signature

Please note: All of the above requested information is necessary for the processing of the Claimant's claim. Any omitted items will delay processing.

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.

Physician's Signature		Date
Physician's Name		
License Number	Specialty	
Phone Number	Fax Number	
Affiliated Medical Facility Information, if applicable Facility Name & Location		

State Notices

The laws of some states require us to furnish you with the following notices:

Alabama	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.
Alaska	A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
Arizona	For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas	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.
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. 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 with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
Delaware	Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
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.
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.
Idaho	Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana	A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
Kentucky	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.
Louisiana	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.
Maine	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
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.
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
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.
New Jersey	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
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.
New York	<p>Auto claims: Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, 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 value of the subject motor vehicle or stated claim for each violation.</p> <p>All others: 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.</p>

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.
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.
Oregon	Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.
Pennsylvania	Motor vehicles: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000. All others: 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 subjects such person to criminal and civil penalties.
Rhode Island	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.
Tennessee	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.
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.
Utah	Workers' Compensation Claims Only: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.
Virginia	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.
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.

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.

Puerto Rico Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.
