CHUBB

**MAIL TO:**
Administrative Concepts, Inc.
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# ACE American Insurance Company

## TRIP CANCELLATION/INTERRUPTION- PROOF OF LOSS

COMPLETE IN DETAIL TO ENSURE PROMPT HANDLING

**Any person who knowingly presents a false or fraudulent claim for payment of 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.**

## Section 1 - Insured Information

Name of Insured: | Member ID #

Last Name | First Name | M.I.

Home Address:

# and Street | City/Town | State | Zip Code

Home Telephone ( ) | Business Telephone ( )

Parent or Guardian (if under 18)

## Section 2 – Trip Information

Program Name:

Group Leader:

Address: | Telephone: ( )

Trip Departure Date: | Scheduled Return Date:

Date Trip Was Cancelled: | Date Incident Occurred **(must complete):**

Enrollment Effective Date:

## Section 3 – Reason for Claim

Please supply a brief description of the circumstances that caused your claim: (attach additional pages if necessary)

Date of Illness or Injury: | If Illness, have you been treated before?:

If Injury, describe:

Name and Address of Attending Physician:

**Illness or Injury: Physician's Statement must be signed by the patient and completed by the patient's physician before the claim can be processed.**

## Section 4 – Physicians Statement

Diagnosis or nature of Illness of Injury:

Date of Illness (first symptom) or Injury: | Date first consulted for this condition:

Hospital confinement dates: From to | Date able to return to work:

Total disability dates: From to | Partial disability dates: From to

Patients account #: | Amount paid: | Balance due:

Place of service: | Diagnosis code and description:

**BY SIGNING 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 a 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

Address: