Baggage Delay / Loss Claim Form

iTravelInsured®

To report a loss, return the required documentation, along with your original, signed claim form to iTravelInsured®, Inc. A delay in the processing of the claim will occur if acceptable proof of loss or an incomplete claim form is submitted. Proof of loss must be submitted within 90 days of the date of loss. iTravelInsured® reserves the right to obtain further information needed to determine eligibility for benefits and the proper payee.

Return complete form via mail, fax, or email to:

iTravelInsured®, Inc.
P.O. Box 88503
Indianapolis, IN 46208-0503
Telephone: 1.866.243.7524 or 1.317.655.9798
Fax: 1.317.655.4505
Email: itravelclaims@itravelinsured.com
www.itravelinsured.com

BAGGAGE DELAY/LOSS - REQUIRED DOCUMENTATION	
Travel Itinerary:	A copy of the original itinerary reflecting the ticket number(s), date and time(s) of the trip.
Refund:	A copy of all documents that reflect amounts paid to you for the delay/loss.
Items:	Provide a detailed list of the items lost, stolen, or damaged in the appropriate section of this form.
Receipts:	Original receipts for items purchased resulting from delay. Original receipts are needed for items lost, stolen or damaged beyond repair. Proof of ownership must be submitted if original receipts are not available.
Incident Report:	An irregularity report, incident 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 finalized settlement statement from the entity *(e.g. airline, cruise line, tour operator, home insurance, credit card, etc.)* that received the incident report.
Damage Baggage Verification:	A repair estimate or documentation from the entity making repairs. The repair estimate/documentation must be on entity's stationary.

Benefits will not be paid for any expenses which have been reimbursed or for any services which have been provided by the common carrier, hotel, or travel supplier, nor will benefits be paid for loss of damage to property covered under any other insurance.

INSURED INFORMATION

Insured's Name *(Last, First, Middle)*:	Policy Number:	
Complete Address:		
Email Address:	Home Telephone Number *(with Area Code)*:	Work Telephone Number *(with Area Code)*:

PART 1. GENERAL INFORMATION

1. Full Name of Claimant: *(If additional travelers, please attach a separate sheet)*		Date of Birth *(Mo., Day, Yr.)*:
Policy Number:	Relationship to Insured:	
2. Full Name of Claimant:		Date of Birth *(Mo., Day, Yr.)*:
Policy Number:	Relationship to Insured:	
3. Full Name of Claimant:		Date of Birth *(Mo., Day, Yr.)*:
Policy Number:	Relationship to Insured:	
4. Full Name of Claimant:		Date of Birth *(Mo., Day, Yr.)*:
Policy Number:	Relationship to Insured:	
Name of Travel Supplier *(e.g. Cruise Line, Airline, etc.)*:		
Travel Agency's Full Name:	Travel Agent's Name:	Telephone Number *(with Area Code)*:
Travel Agency's Mailing Address:		Email Address:

Please check the box for benefits requested: ❑ Baggage Delay ❑ Baggage Loss

PART 2. EXPLANATION OF DELAY/LOSS

Describe in detail what occured:

Date of Delay/Loss *(Mo., Day, Yr.)*:	Time of Delay/Loss:	Location of Delay/Loss *(City, State, Country)*:
Date Baggage Returned *(Mo., Day, Yr.)*:	Length of Baggage Delay *(Days / Hours)*:	Total Baggage Delay/Loss Expenditures:

Did you receive compensation from any other party? ❑ Yes ❑ No If Yes, the amount and payor: $

PART 3. SCHEDULE OF EXPENDITURES. Attach additional sheets if necessary.

Description of Item(s) Purchased	Date & Place of Purchase *(Mo., Day, Yr.)*	Cost *(List Currency)*
	Total Amount Claiming:	

Receipt Reminder: *Original receipt(s) are needed.*

PART 4. SCHEDULE OF BAGGAGE LOST/DAMAGED CONTENTS. Attach additional sheets if necessary.

Description of Item(s) Lost	Original Date of Purchase *(Mo., Day, Yr.)*	Cost *(List Currency)*
	Total Amount Claiming:	

Receipt Reminder: *Original receipt(s) are needed. Proof of ownership must be submitted if original receipts are not available.*

PART 5. OTHER COVERAGE			
Do you have any other insurance coverage related to the loss *(e.g. travel, homeowner, etc.)*?			❑ Yes ❑ No
Do you have any other travel insurance coverage *(i.e. through credit card(s) used to purchase the items)*?			❑ Yes ❑ No
Did you report the loss to any other insurance company?			❑ Yes ❑ No
If Yes, which company:			
Name of Company: 1. _____ Address:_____ _____ 2. _____ Address:_____ _____ 3. _____ Address:_____ _____ *(Please attach a separate sheet if necessary)*	Policy/Certificate Number: _____ _____ _____	Telephone Number *(with Area Code)*: _____ _____ _____	Website _____ _____ _____

CLAIM FORM FRAUD STATEMENT

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

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.

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.

ALASKA and 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, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

CALIFORNIA: For your protection California law requires the following to appear on this form: 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.

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.

FLORIDA: WARNING: 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.

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.

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.

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, which is a crime and subjects such person to criminal and civil penalties.

OKLAHOMA: 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.

TENNESSEE and 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.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

Insured Signature _____ Date_____

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 provider, 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, iTravelInsured®, 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 iTravelInsured® 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 iTravelInsured®. A copy of this shall be as valid as the original. The undersigned acknowledges and understands there is the potential for the information to be subject to redisclosure by the recipient and to no longer be protected by applicable privacy and confidentiality laws.

The undersigned represents and warrants information or documents provided to iTravelInsured® 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 iTravelInsured® as being complete and correct, and 2) benefits under any contract will be paid only if iTravelInsured® decides the applicant is entitled to them.

Signature of Insured/Claimant 1:	Date *(Mo., Day, Yr.)*:
Signature of Insured/Claimant 2:	Date *(Mo., Day, Yr.)*:
Signature of Insured/Claimant 3:	Date *(Mo., Day, Yr.)*:
Signature of Insured/Claimant 4:	Date *(Mo., Day, Yr.)*: