1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH REQUIRED DOCUMENTATION
3. MAIL TO *HSR*

E-MAIL: StarrTravelClaims@hsri.com

ASSIST CARD CORP. OF AMERICA
CLAIMS MAILING ADDRESS
ATTENTION: Health Special Risk, Inc.

HSR Plaza II
4100 Medical Parkway
Carrollton, Texas 75007
972-512-5600, Fax 972-512-5820
Toll Free: 866-345-0975

Policy Name: _____

Policy Number: _____

TRIP CANCELLATION / TRIP INTERRUPTION / TRIP DELAY / MISSED CONNECTION

SECTION 1 - INSURED

Type of Loss (check one): ☐ Trip Cancellation ☐ Trip Interruption ☐ Trip Delay ☐ Missed Connection

Claimant's Name (Insured): _____

AC/Policy #: _____ Date of Birth: _____ Date of Incident: _____

Home Address: _____

Phone #: _____ Email Address: _____

SECTION 2 – TRIP

Date of Initial Trip Deposit: ___/___/____ Scheduled Departure Date: ___/___/____ Scheduled Return Date: ___/___/____

Scheduled Departure Location: _____ Scheduled Return Location: _____

If you reason for this Claim is due to a **Trip Delay**, please provide the length of time and reason for the **Delay**:

_____

If your reason for this Claim is due to a **Missed Connection**, please provide the length of time and reason for the **Missed Connection**.

_____

Was the reason for the Trip Cancellation, Interruption, Delay or Missed Connection of a Medical or Non-Medical Nature?

☐ Yes ☐ No

If Yes, please complete the following section and include the **Physician Statement Form** completed by the Attending Physician.

(See **Claim Documentation Requirements** for additional supporting medical documents)

If No, fully describe the detail in circumstances causing the Cancellation, Interruption, Delay or Missed Connection of your trip.

Name of Patient: _____ Relationship to Insured: _____

Are you a U.S. Citizen? ☐ Yes ☐ No If not, Place or Residence: _____

Home Address of Patient: _____

Date Condition First Appeared: _____ Date First Consulted Physician: _____

Location Where Condition Occurred: _____

Give Nature of Sickness/ Injury (Diagnosis): _____

_____

Fully Describe How Sickness/ Injury Occurred: _____

_____

Was there Previous Treatment for this Condition prior to the purchase of this Policy? ☐ Yes ☐ No

If Yes, When? _____

Name of Physician Who First Treated This Condition: _____

Physician Address: _____

Physician Specialty: _____ Phone #:_____ Fax #: _____

Name of Other Physician Who Has Treated This Condition: _____

Physician Address: _____

Physician Specialty: _____ Phone #:_____ Fax #: _____

Name of Patient's Primary Care Physician: _____

Primary Physician Address: _____

Primary Physician Phone #:_____ Fax #: _____

Name of Hospital (if hospitalized): _____

Hospital Address: _____

Date of Admit: ____/____/_____ Date of Discharge: ____/____/_____ Hospital Phone #: _____

If Injury was a result of an Accident, was a report filed? ☐ Yes ☐ No If Yes, provide a copy of the Report.

SECTION 3 – PROOF OF LOSS

Unused Airfare and Cancellation Penalties $ _____

Do you intend to use the value of your Unused Ticket within One Year from the Date of Issuance? ☐ Yes ☐ No

Unused Land/ Sea $ _____

Unused Tour(s) $ _____

Additional Meals and Accommodations $ _____

Cancellation Penalties/ Non-Refundable Fees $ _____

Total Expenses $ _____

Subtract Refunds/ Reimbursements $ _____

Total Amount of Claim $ _____

SECTION 4 - AUTHORIZATION

Any person who knowingly and with intent to defraud any insurance company or other persons, for example by filing a statement of claim which contains any materially false, incomplete or misleading information, is committing a fraudulent insurance act, and is therefore subject to criminal prosecution and civil penalties.

I have read the foregoing and the answers provided are true and complete to the best of my knowledge.

Claimant's Signature _____ Date _____

By entering your name above, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.

NOTE TO INSURED:

- PLEASE BE SURE TO INCLUDE THE **PHYSICIAN STATEMENT FORM** COMPLETED BY THE ATTENDING PHYSICIAN **IF** CANCELLING THE TRIP OR TRIP WAS INTERRUPTED FOR A MEDICAL REASON.
- PLEASE COMPLETE AND RETURN THE CLAIM FORM(S) ALONG WITH THE **CLAIM DOCUMENTATION REQUIREMENTS** TO THE CLAIMS MAILING ADDRESS LISTED BELOW AND TO THE ATTENTION OF **CLAIMS TEAM.**

PHYSICIAN STATEMENT FORM

TO BE COMPLETED BY PATIENT: DATE: _____

Name of Patient: _____ Relationship to Insured: _____

AC/Policy #: _____ Date of Birth: _____ Social Security #: _____

Home Address: _____

Phone #: _____ Email Address: _____

TO BE COMPLETED BY ATTENDING PHYSICIAN:

Physician Name: _____

Physician Address: _____

Physician Tax ID#: _____ Phone #:_____ Fax #: _____

Did you perform a physical examination of the Patient? ☐ Yes ☐ No If Yes, When? _____

Did you advise the Patient to cancel or interrupt their trip? ☐ Yes ☐ No If Yes, When? _____

Please advice the diagnosis and reason why you advised the Patient to Cancel or Interrupt their trip:

_____

_____

Date symptom(s) first appeared: _____ Date Patient initially consulted for this condition: _____

Please list all dates that you provided treatment for this condition: _____

_____

Have you ever treated the Patient for this condition before? ☐ Yes ☐ No If Yes, When? _____

Is the condition a complication of an underlying condition? ☐ Yes ☐ No

Do you know if the Patient has been treated by any other Physician or Specialist for this condition? ☐ Yes ☐ No

If Yes, provide the name and address of Physician or Specialist _____

_____

Was the Patient referred to you by another Physician or Specialist? ☐ Yes ☐ No

If Yes, provide the name and address of Physician or Specialist: _____

_____

ICD-10 Code: _____

Was the Patient ever hospitalized for this condition? ☐ Yes ☐ No

Name and Address of Hospital: _____

Date of Admit: _____ Date of Discharge: _____ Hospital Phone #: _____

Additional Comments: _____

_____

_____

FRAUD WARNING: ANY PERSON WHO KNOWLINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY OR OTHER PERSON, WHO FILES A STATEMENT OF CLAIM CONTANING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERTO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES

I have read the foregoing and the above information is true and complete to the best of my knowledge.

_____	_____	_____
Print Name of Physician	Signature of Physician	Date

HOW TO FILE A CLAIM

Listed below are important instructions and comments about filing a claim.

- Completed and signed Claim Form
- Completed and signed Physician Statement Form
- E-Ticket receipt or original paper ticket from airline
- Statement from common carrier stating the reason for delay or missed connection, date of delay or missed connection and time length of delay or missed connection.
- Statement from travel supplier and/or common carrier advising amount of refund(s) or penalties incurred on the unused, non-refundable travel arrangements
- Proof of any refund(s) received (copy of check, credit card statement, bank statement, invoice from travel supplier showing amount refunded).
- Proof of trip payment (copy of check, credit card statement, bank statement)
  If cash payment was made, provide receipt from travel supplier/agent showing the date and payment amount.
- Copy of trip itinerary
- Proof from airline of remaining value for all unused tickets
- Supporting medical information from the attending physician and/or hospital (if cancelling or interrupting for medical reasons)
- Written statement from travel supplier/agent indicating the date of cancellation
- Receipts for meals or accommodations due to a cancellation, delay or missed connection
- Receipts for any additional transportation expenses incurred
- Copy of report if injury occurred from an accident
- Copy of Death Certificate if death is the reason for the claim

If you have any questions, please contact Customer Service at (866) 345-0975. They are available from 8:00 a.m. thru 6:00 p.m. Central time, Monday – Friday. You may also forward any documents by fax to (972) 512-5820.

Health Special Risk, Inc.
4100 Medical Parkway
Carrollton, TX 75007

FRAUD STATEMENTS

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.

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.

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, Louisiana, Maryland, West Virginia &Rhode Island: Warning: 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 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.

Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Delaware, Idaho, Indiana: 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: 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.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Georgia: Any natural person who knowingly or willfully

1) Makes or aids in the making of any false or fraudulent statement or representation of any material fact or thing:
   a) In any written statement;
   b) In the filing of a claim; or
   c) In the receiving of money for an application for a policy of insurance for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer;
2) Receives money for the purpose of purchasing insurance and converts such money to such persons own benefit;
3) Issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders; or
4) Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement for the purpose of fraudulently obtaining money or benefit from an insurer commits the crime of insurance fraud.

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.

Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another 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, and subjects the person to criminal and civil penalties.

Minnesota; A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

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 and 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.

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.

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: Warning: Any person who knowingly, and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud.

Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes 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.