Claim Filing Instructions

Read the instructions for the type of claim you need to file, you may have more than one.

Trip Cancellation

You were unable to depart on your covered trip.

1. Complete all applicable information starting on page 2.
2. If cancellation was the result of an illness/injury, please have the patient's physician complete the "Physician's Statement" on the attached form.
3. Please submit proof of payment for claimed expenses. Acceptable forms of proof of payment include a credit card statement and/or a copy of the front and back of the negotiated check.
4. Submit copies of the invoice/reservation for hotel, cruise, and tour bookings.
5. Submit your airline e-ticket if you have one.
6. Submit the travel supplier cancellation notice. This notice should contain the reservation/itinerary/booking information, date of cancellation, and the penalties.
7. Employment termination, submit - Termination letter or other documentation from employer indicating dates of employment.

Trip Interruption

You started on your trip and then had to return home due to an unforeseen event.

1. Complete all applicable information starting on page 2.
2. If the interruption was the result of an illness/injury, please have the patient's physician complete the "Physician's Statement" on the attached claim form – medical records from the date of service are applicable in lieu of a completed "Physician's Statement."
3. Please submit proof of payment for claimed expenses. Acceptable forms of proof of payment include a credit card statement and/or a copy of the front and back of the negotiated check.
4. Submit your airline e-ticket (please include original and new flight itineraries).

Single Supplement

Booked a trip with a companion who canceled, resulting in additional charges for you.

1. Complete all applicable information starting on page 2.
2. Please submit all revised booking confirmations showing the revised total cost.

1 Reason for Claim

☐ Trip Cancellation ☐ Trip Interruption ☐ Trip Delay *You may check more than one.*

EF PROGRAM NAME:

☐ EF Educational Tours ☐ Go Ahead Tours ☐ Ultimate Break ☐ College Study Tours ☐ Gap Year ☐ Explore America

Primary Insured's Information

2 Name of Primary Insured	**3** Date of birth MM/DD/YYYY		
4 Account Number	**5** Preferred phone number		
6 Email address	**7** Fax number		
8 Mailing address (if different than home)	**9** City	**10** State	**11** Zip code
12 Home address	**13** City	**14** State	**15** Zip code
16 Preferred method of contact: ☐ Mail ☐ Email ☐ Phone			

Travel Supplier / Provider Information

17 Company name	**18** Phone number		
19 Company mailing address	**20** City	**21** State	**22** Zip code
23 Scheduled date of departure MM/DD/YYYY	**24** Scheduled date of return MM/DD/YYYY		
25 Actual date of return MM/DD/YYYY (trip interruption/trip delay)			

Claimed Expenses

Category	Amount	Required Supporting Documents
26 Airfare	$	E-ticket receipt or original paper airline tickets
27 Lodging	$	Documents confirming your reservation/payment/partial payment
28 Tour(s)	$	Copy of the invoice
29 Cruise ship	$	Booking confirmation
30 Other	$	Meals, taxi, any additional expenses
31 Total expenses	$ 0.00	
32 Refunds	$	Examples: account credits, cash refunds, trip or meal voucher, etc.
33 Total claimed	$ 0	

34 If You Are Claiming Airline Tickets, Please Complete The Below Section

Your airline tickets may have value up to one year from the original scheduled departure date. Please indicate below whether you will be exchanging your tickets for another trip. Please note: Your signature on this agreement is not a guarantee of payment. Claim determinations are subject to the terms and conditions of the plan document.

☐ I (We) will not be using our airline ticket(s). Please enclose a copy of all electronic ticket confirmation(s).

☐ I (We) will be exchanging our airline ticket(s) for future travel. Please enclose a copy of all electronic ticket confirmation(s) along with documentation for the cost you incurred for the exchange.

Traveling Companions

35 Companion name	**36** Relationship
37 Companion name	**38** Relationship
39 Companion name	**40** Relationship
41 Companion name	**42** Relationship

43 Reason for Cancellation / Delay / Interruption

If Cancellation / Delay / Interruption Due To Medical Reasons

44 Name of person having sickness or injury	**45** Date of birth MM/DD/YYYY
46 Relationship to Primary Insured	
47a Has the person named in question 44 received medical attention for the mentioned symptoms or illness? ☐ **Yes** ☐ **No**	**47b** If **YES**, please indicate the date you were last treated MM/DD/YYYY
48 Period of Hospitalization (if applicable) MM/DD/YYYY From:	To:

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 Seven Corners 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.

49 Date MM/DD/YYYY	**50** Signature (Signature of Person Suffering Illness or Injury or legally authorized representative)

Physician's Statement – To Be Completed By Physician Only

51 Name of doctor	**52** Office phone number		**53** Office fax number
54 Office mailing address	**55** City	**56** State	**57** Zip code
58 Name of patient	**59** Date of birth MM/DD/YYYY		
60 Diagnosis that resulted in cancellation/interruption of trip			
61 Date symptoms first appeared or accident occurred MM/DD/YYYY	**62** Date of first treatment for listed diagnosis MM/DD/YYYY		
63 Was patient treated by anyone else? ☐ **Yes** ☐ **No**	**63a** If **YES**, by whom?		**63b** If **YES**, when? MM/DD/YYYY
64 Was patient prohibited to travel due to this illness/injury? ☐ **Yes** ☐ **No**			
65 Date completed MM/DD/YYYY	**66** Physician's signature		

Documentation Requirements

67 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.	
	Airline Ticket Stub/Receipt
	Copies of canceled checks or credit card statements with an invoice from your Travel Provider showing the date of your deposit. If you wish to waive the pre-existing condition exclusion on your claim, you must submit proof that you bought this insurance plan within 20 days of your first payment for air/land/sea arranements.
	Police Report
	Statement from Hotel/Motel, Airline Carrier or Airport Facility that concerns your Cancellation/Delay. Note: Any cancellation or delay of flight must be documented by the airline.
	Car Rental Agreement
	Copies of reimbursement statements issued by an airline carrier, airport facility, car rental agency, travel agent, hotel/motel or other similar establishment or any other insurance company providing reimbursement to you for the loss.
	Original purchase receipts for additional expenses
	Report from common carrier confirming delay
	Employment Termination letter or other documentation from employer indicating dates of employment.
	Other (please describe)

Other Insurance / Authorization

68a Do you have any other travel or out-of-country insurance through an employer, spouse's employer, retirement plan or credit card? ☐ **Yes** ☐ **No**	**68b** If **YES**, please indicate name of insurance company
69 Plan number	**70** Credit card issuing bank

I AUTHORIZE any insurance company, physician, hospital, and other health care providers, any travel organization or agency, airline carrier, 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, to release any information requested regarding this claim and the loss reported.

I UNDERSTAND the information obtained by use of the authorization, will be used by Seven Corners to determine eligibility for benefits under this plan. Any information obtained will not be released by Seven Corners to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I further authorize.

I KNOW that I may request to receive a copy of the Authorization. I AGREE that a photographic copy of this authorization is as valid as the original. I AGREE that this Authorization shall be valid for two and one half years from the date shown below. I UNDERSTAND that it is illegal to knowingly file a false or fraudulent claim or to knowingly help someone else file one.

71 Signature	**72** Date MM/DD/YYYY

Send this form and any accompanying documents to Seven Corners using any of the following methods:

MAIL	FAX	EMAIL
Seven Corners, Inc. **Attn: Claims** 303 Congressional Boulevard Carmel, IN 46032 USA (Allow mail 7-10 days for delivery.)	(+01) 317-575-2256	tourclaims@sevencorners.com

Call for help: Local **1.317.582.2658** or Toll-free **1.866.887.7148**

Payment Authorization Form

- To prevent any delays in claims handling, please be sure to sign this form.
- The ***Name*** in contact information must match exactly the name on the ACH, checking, or wire transfer account.
- Joint accounts require all names.

Contact Information

Name *Account Holder(s)*	Telephone		
Email address	I authorize Seven Corners, Inc. to contact me using this email address to discuss and/or inform me of payment confirmation. ☐ **yes** ☐ **no**		
Mailing address (P.O. boxes are not accepted)	City	State/Province/Region	ZIP/Postcode

1 Payment Type

☐ Check (check will ship to address above)
☐ ACH/EFT: US $ Canada(CAD) $ – complete section 2
☐ International Wire Transfer – complete section 3

2 U.S. Account Information

Account type: ☐ Checking ☐ Savings		Full Bank Name:		
Bank street address		City	State	Zip Code/ Postcode
ABA routing number	Account number		SWIFT BIC	

3 International/non-U.S. Account Information - Complete for payment through bank transfer outside the U.S.

Bank's full name			
Bank street address	City	State/Province/Region	Zip Code/ Postcode
Account number	Routing Number (BLZ, BSB, TRNO, branch code, etc.)		
IBAN	SWIFT BIC	Preferred reimbursement currency	

REGULATORY INFORMATION

Bank phone number	Identification number
	Account type: ☐ ID ☐ NIT ☐ RIF ☐ CPF ☐ CNPJ ☐ RUT ☐ CUIT ☐ OTHER

I hereby authorize Seven Corners, Inc. (hereinafter COMPANY) to mail any payments to the above listed address and to deposit any amounts owed me for reimbursement of medical expenses or services rendered by initiating credit entries to my account at the financial institution (hereby BANK) indicated above. Further, I authorize BANK to accept and to credit any credit entries indicated by COMPANY to my account. In the event that COMPANY erroneously deposits funds in my account (by way of example, I am not entitled to the funds or the amount of deposit Is incorrect or such funds are deposited in the wrong account), I authorize COMPANY to debit or credit my account in the amount necessary to correct the initial deposit, but in no case shall any debit exceed the amount of the initial deposit. I further agree COMPANY is not responsible for any transaction fees charged and will release Seven Corners of any liability in the event of lost or stolen payments.

Account holder signature	Date