



## Claim Form

### General Information

Contact Information	
Name of insured: _____	Social Security Number ____ -- ____ -- _____
Date of birth: _____	Home telephone: (____) _____ -- _____
Place of birth: _____	Work telephone: (____) _____ -- _____
	E-mail address: _____@_____
<i>Home Address</i>	<i>Mailing Address, if different from Home Address</i>
Street: _____	Street: _____
City: _____ State: _____ Zip Code: _____	City: _____ State: _____ Zip Code: _____
Preferred method of contact:      Mail <input type="checkbox"/> E-mail <input type="checkbox"/>	Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/>

Plan Information	Trip Information
Confirmation/Policy ID #: _____	Departure date: _____
<u>or</u> Product ID #: _____	Return date: _____
<u>or</u> Group #: _____	Original destination: _____
<u>or</u> Company ID #: _____	Travel agency name: _____
<u>or</u> Membership #: _____	Date of initial trip deposit/payment: ____ / ____ / ____
	Agent's name: _____
	Agent's phone number: (____) _____ -- _____
	Agent's e-mail address: _____@_____

Traveling Companions (please indicate name and relationship to you)	
1. _____	3. _____
2. _____	4. _____

Claim Information	
Reason for filing this claim (short description) _____	Date incident occurred: ____ / ____ / _____
_____	Do you have other insurance that may cover this event?
_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	If Yes, then please provide the name of the insurance company _____

E-mail to: [claimsinqury@accessamerica.com](mailto:claimsinqury@accessamerica.com)  
Mail to: ACCESS AMERICA, P.O. BOX 72031, RICHMOND, VA 23255-2031  
Call: 800-334-7525 Fax to: 804-673-1469  
We are available 24 hours a day.

Insurance underwritten by BCS Insurance Company or Jefferson Insurance Company  
Please refer to your policy or letter of confirmation to determine your underwriter  
Plan administered by World Access Service Corp., a company of Mondial Assistance



## Emergency Medical / Dental

### Details of Loss

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

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Was your medical emergency caused by an accident?

Yes

Please attach a copy of the accident report to this form.

Do you believe a third party was responsible?       Yes       No

No

Name of the third party: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone #: (\_\_\_\_) \_\_\_\_ -- \_\_\_\_\_

Name(s) of your health insurance provider(s): \_\_\_\_\_

Coverage may be secondary to your other insurance. A deductible may apply, as outlined in your letter of confirmation.

### Claimed Expenses (please attach receipts and reports for all items you are claiming)

<u>Description of Expenses</u>	<u>Where were the Expenses Incurred?</u>	<u>Amount</u>
		\$ _____
		\$ _____
		\$ _____
		\$ _____
<b>Total expenses:</b>		<b>\$ _____</b>
Subtract credits/reimbursements:		\$ _____
<b>Total claimed amount:</b>		<b>\$ _____</b>

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**PLEASE READ AND SIGN THIS FORM.  
FAILURE TO SIGN AND DATE MAY DELAY THE REVIEW OF YOUR CLAIM.**

**FRAUD WARNING:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, who files a statement of claim containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to criminal prosecution, civil penalties and forfeiture of insurance benefits.

**ALASKA FRAUD WARNING:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

**CALIFORNIA FRAUD WARNING:** 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.

**PENNSYLVANIA FRAUD WARNING:** 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.

**AUTHORIZATION**

I authorize any insurance company, travel organization, or any other person or entity to release information regarding this claim. I understand that this information will be used by World Access Service Corp., claim administrator, or its authorized representatives for the purpose of evaluating and determining coverage for this claim.

By signing this claim form, I certify that all information given above is true and complete to the best of my knowledge.

Signature: \_\_\_\_\_

Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name: \_\_\_\_\_

The status of your claim can be easily viewed at [www.eclaimsline.com/travel](http://www.eclaimsline.com/travel) by clicking on the "Check Claim Status" link.

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