RoamRight®
VENTURE FARTHER. TRAVEL SMARTER.

Trip Interruption Claim Form

Arch Insurance Company®

Claims Department: Executive Plaza IV, 11350 McCormick Road, Suite 102, Hunt Valley, MD 21031
Phone No: 1-855-762-6252 | **Fax:** 443-279-2901
Email: claims@roamright.com

Any person who knowingly and with intent to injure, defraud or deceive and insurance company, files a statement claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable by law.

Trip Interruption Claim Instructions

Please complete and sign the Trip Interruption claim form in full and return it with specific documentation noted for your claim.

For all claims, submit:

- Copies of your original travel documents including the cruise or tour brochure, flight itinerary or e-ticket showing the ticket numbers and date of travel, hotel or other pre-paid expenses;
- Proof of payment of the claimed travel expenses – copies of both sides of checks, copies of credit card statements or receipts for cash payments;
- Copies of any refunds, adjustments or credits provided by the tour operator, airlines or other travel providers;
- If you did not receive any refunds, adjustments or credits, provide a copy of the trip cancellation policy or a letter from the tour operator stating that no refunds, adjustments or credits were available;
- For international flights, please request a refund from the airline and provide us with a copy of the refund payment or written denial;
- Proof of loss:
    - Illness or Injury – An Attending Physician's Statement fully completed by the patient's treating physician; Copies of medical records of your condition and treatment;
    - Death – A copy of the Death Certificate;
    - Other – Appropriate documentation showing the reason that you interrupted your trip;

If you are filing a claim for additional expenses that you incurred due to the interruption of your trip, submit copies of all of your invoices and receipts for additional meals, lodging, and transportation expenses.

Your claim should be submitted to the address at the top of these instructions.

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Section 1 - Information about Insured

To be completed by the Insured Claiming Benefits

Name of Claimant / Insured	Policy No.	Phone No. ( )
Address		
Email Address	Male ☐ Female ☐	Date of Birth
Traveling Companion(s) / Relationship	Trip Departure Date	Trip Return Date
	Initial Trip Deposit Date	
	Trip Interruption Date	

Do you have other travel or other insurance that may provide coverage for this claim? Yes ☐ No ☐

If so, has claim been submitted to the other company? Yes ☐ No ☐

Name, Address & Phone No. of the other insurance company

Policy No.

Reason for Interruption

☐ Illness — Date Incident Occurred

☐ Injury — Date of Injury

☐ Other — Onset Date of Illness

Briefly explain the circumstances of your claim:

If condition was the result of an accident, please provide a detailed explanation:

Was a motor vehicle involved? Yes ☐ No ☐ If Yes, please list the name of the involved parties, their insurance carriers and policy numbers

Was a police or accident report filed? Yes ☐ No ☐ If yes, submit a copy of the police or accident report

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Section 2 - Claimed Expenses

Enter the total of all claimed expenses in the table below. You will need to provide supporting documentation in order for the claim to be processed. See the Trip Interruption Claim Instructions for required documents.

Claimed Expenses

Category	Amount
Unused Airfare Expense**	$ _____
Unused Cruise Expense	$ _____
Unused Tour Expense	$ _____
Unused Local Transportation Expense	$ _____
Unused Hotel Expense	$ _____
Additional Airfare Expense	$ _____
Additional Hotel Expense	$ _____
Additional Food Expense	$ _____
Additional Ground Transportation Expense	$ _____
Other	$ _____
Total Expenses	$ _____
Refunds/Credits Received	$ _____
Claimed Expenses	$ _____

** If you are claiming an amount for unused airfare, do you intend on using the tickets within one year of the issue date?

Yes ☐ No ☐

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I have read the foregoing, and the above answers are true and complete according to the best of my knowledge and belief.

_____ _____

Signature of Claimant **Date**

The laws of some states require us to furnish you with the following notices:

WARNING. Any person who knowingly:

Alaska: and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona, Arkansas and Rhode Island: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or specific to AR and RI: 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 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.

Delaware: and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: 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: and with intent to injure, defraud, or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky, New York and Pennsylvania: and with intent to defraud any insurance company or other person files an application for insurance, or files a statement of claim, containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime, specific to PA: subjects such person to criminal and civil penalties and specific to NY: 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.

Louisiana, New Mexico, Texas and West Virginia: presents a false or fraudulent claim for the payment of a loss (or specific to LA, TX and W VA: who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (or specific to NM: to civil fines and criminal penalties.)

Maryland: and willfully presents a false or fraudulent claim for payment of loss or benefit or who knowingly and 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 Jersey: files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: 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: 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: and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto, may be subject to prosecution for insurance fraud.

Puerto Rico: and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

WARNING:

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.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maine/Washington: 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.

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

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.

Tennessee and Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurer or insurance company for the purpose of defrauding the insurer or insurance company. Penalties include imprisonment, fines and denial of insurance benefits.

Authorization to Disclose Information

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Arch insurance Company, or it's authorized representative, Administrative Concepts Inc. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past.

To any insurance company, any travel organization or agency, airline carrier, cruise line, your operator, 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: I authorize the release any information requested regarding this claim and the loss reported.

The company will use this information to determine if any claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigation or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effect and valid as the original and shall remain in effect for one year from the date of authorization.

I certify that the information given by me in support of my claim is true and correct. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution or insurance fraud.

_____ _____

Patient's or Authorized Representative's Signature **Date**

_____

If Authorized Representative, Relationship to Patient

_____

or Legal Designation

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Attending Physician's Statement
Trip Cancellation & Interruption Claims

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To be completed by Physician Rendering Treatment

Name of Claimant / Insured	Name of Patient	Policy No.
Address		
Male ☐ Female ☐	Date of Birth	Trip Departure Date / Diagnosis/ICD-9 Code
What is the exact date that the symptoms first appeared?	When did the patient first consult you for this condition?	
List all dates of treatment		
Did you advise patient to cancel or interrupt the trip due to the patient's medical condition? Yes ☐ No ☐		
If Yes, Please explain.		
When did you advise the patient to cancel or interrupt their trip?	Has patient ever had this condition before? If so, when?	
Is this condition an exacerbation or a complication of an existing condition? Yes ☐ No ☐	If so, what was that condition?	
When was the patient treated for that condition?	List all dates of prior treatment	
Name of the physician who treated that underlying or original condition	Was the patient referred to you by another physician? Yes ☐ No ☐	
Name of Referring Physician	Phone No.	
Was the Patient Hospitalized? Yes ☐ No ☐	Was this an emergency room admission? Yes ☐ No ☐	
Name of Hospital	Date Admitted	Date Discharged

Please note: All of the above requested information is necessary for the processing of the Claimant/Insured's claim. Any omitted items will delay processing. Please attach copies of the patient's office records for the 6 months prior to the date that you advised the patient to cancel or to interrupt their trip.

Physician Rendering Treatment Information and Signature

Physician's Name	Physician's License No.	
Physician's Speciality	Phone No. ( )	Fax No. ( )

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I have read the foregoing, and the above answers are true and complete according to the best of my knowledge and belief.

Signature of Physician **Date**