



Mail to: ACE American Insurance Company
P.O. Box 5124
Scranton, PA
800-336-0627
302-476-7857 fax
ACEAandHClaims@acegroup.com

Group Name: The University of Texas System
Policy Number: GLMN04969340

TRIP CANCELLATION/ INTERRUPTION/DELAY

Please print except where signature is required

Section 1 – Insured Information

Insured's Name _____
Home Address _____ City, State, Zip _____
Parent or Guardian (if under18) _____
Home Telephone () _____ Business Telephone () _____

Section 2 – Trip Information

Program Name _____
Group Leader _____
Address _____ Telephone () _____
Enrollment Effective Date _____
Trip Departure Date _____ Scheduled Return Date _____
Date incident occurred (**must complete**) _____
Date trip cancelled/interrupted/delayed: _____

Section 3 – Reason for Claim

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

Illness or Injury (Note: Physician's Statement must be signed by the patient and completed by the patient's physician before the claim can be processed.

Section 4 – Physicians Statement

Diagnosis or nature of illness or injury _____

Date of illness (first symptom) or injury _____

Date first consulted for this condition _____

Hospital confinement dates: From _____ To _____

Date able to return to work _____

Total disability dates: From _____ To _____ Partial disability dates: From _____ To _____

Place of service _____ Diagnosis code and description _____

Physician's Signature _____ Date _____

Address and Telephone Number: _____

BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I agree that a photographic copy of this Authorization shall be a valid as the original.

I understand that I or my authorized representative may request a copy of this authorization.

I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative | Dated

Address: _____

IMPORTANT NOTICE: Written *notice of claim* must be provided within 90 days of the loss. Written *proof of loss* must be provided within 90 days after the date of loss. If it cannot be provided within that time period, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted more than one year from the date it was otherwise required.

Fraud Warning: Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalized fraud stated. ACE USA Accident & Health has adopted the fraud warning language prescribed by the District of Columbia as its standard fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications and enrollment forms.

District of Columbia Generic 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.

The following states have required us to use state specific language as follows:

California

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

Any person who knowingly presents 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.

Florida

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.

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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Oklahoma

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the process of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania:

Any person who knowingly and with intent to defraud any insurance company or other 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 such person to criminal and civil penalties.

Maryland/Oregon

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 may be guilty of insurance fraud.

Virginia

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 may have violated state law.