# AXA Trip Cancellation

## Claim Form & Claimant's Statement

Dear AXA Customer,

Thank you for notifying AXA Assistance USA of your recent request to register a travel insurance claim. Please find a claim form for completion enclosed. In addition, the following information is needed to process your claim.

- Completed claim form
- Policy Verification
- Booking confirmation (E-ticket, proof of purchase of cruise tickets, train passes, etc)
- Original unused non-refundable tickets (e-ticket is required)/accommodations
- Evidence from travel supplier of cancellation reflecting any costs reimbursed by them
- Completed Attending Physician Statement (page 3 of claim form) and/or documentation from accredited physician confirming need for cancellation (if due to medical reasons)
- Documentation from all appropriate parties providing reason for cancellation if due to a non-medical reason
- Documentation from employer of dates of employment and reason for cancellation (if canceling for work reasons)
- Any additional documentation of circumstances leading to the cancellation of your trip
- Death certificate if applicable

Please send the completed forms, your itemized bills, all supporting documents, and a detailed explanation for submitting the claim. We recommend that you keep the originals for your records and send all copies to the following address:

AXA Assistance USA
On Behalf of Nationwide Mutual Insurance Company and Affiliated Companies
P.O. Box 26222
Tampa, FL 33623

Claims may also be emailed to **AXAClaims@cbpinsure.com.** Once your claim form and all documents are received, your claim will be processed by AXA Assistance USA within 30 days.

Our claims office is available MTWF 8:30am-5pm ET and TH 9:30am-5pm ET. Should you have any questions, please contact us at (888) 957-5015 or **AXAClaims@cbpinsure.com.** To expedite your inquiry, please have your policy number available.

Sincerely,

**AXA Assistance USA**

## PARTICIPANT'S INFORMATION:

Plan Number: _____

Name(s) of all claimants:

1._____

2._____

3._____

4._____

Email Address: _____ Home Phone #: (_____) _____

Work Phone: (_____) _____/_____ Cell #: (_____) _____

Address:_____ City:_____ State:____ Zip Code:_____

## TRAVEL SUPPLIER / PROVIDER INFORMATION:

If your trip arrangements were made through a Travel Agent – please provide the agent's information, if not – then provide the information as related to the cruise line, land operator or airline as applicable:

Company Name: _____Address: _____

City: _____ State: _____ Zip: _____ Contact: _____ Phone #: (_____)_____

Date Travel Protection Plan was purchased: ____/____/____ Date of initial payment deposit: ____/_____/_____

Scheduled Date of Departure: _____/_____/_____ Scheduled Date of Return: _____/_____/_____

If not included in package, how was air travel arranged? _____

## LOSS INFORMATION:

After completing this section, attach copies of all travel documents (original airline tickets, hotel receipts, travel itinerary, tour cost, etc.) supporting penalties, nonrefundable charges incurred by you due to cancellation,

| Company name: (airline/hotel/cruise/travel agent/etc.) | Amount paid: | Amount of loss: (non-refundable amount) | Have you received reimbursement? | If so, from whom? | How much? |
|---|---|---|---|---|---|
| | $ | $ | Yes No | | $ |
| | $ | $ | Yes No | | $ |
| | $ | $ | Yes No | | $ |
| | $ | $ | Yes No | | $ |
| Total | $ | $ | | | $ |

## REASON FOR CANCELLATION:

Date Trip was cancelled with Travel Supplier: __/___/___ Reason for Cancellation:_____

_____

_____

## IF CANCELLATION IS DUE TO MEDICAL REASONS:

Name of person having sickness or injury: _____

His / Her date of birth: ___/_____/___ His / Her relationship to claimant: _____

Date Sickness or Injury began:___/___/____ Date ended: ____/____/___

Nature of Sickness or Injury (If Injury, describe accident, including date and place): _____

_____

_____

Period of hospitalization (If applicable): From____/____/____ To: ____/____/____

### To Be Completed by the Attending Physician

Name of patient:_____ Name of Doctor:_____

Address: _____

Office Phone #: (_____)_____ Office Fax #: (_____)_____

Date of Birth: _____/_____/_____ Date symptoms first appeared or accident occurred: _____/_____/_____

Date of first treatment: _____/_____/_____ Was patient treated by someone else? YES NO

Diagnosis: _____

If so, by whom? _____ When? _____

If patient is the traveler, did you prohibit patient's traveling by air or otherwise due to this injury/illness? YES NO

Has the patient received medication or other treatment for this condition, or for a related condition, by you or any other Physician during the 90 days immediately prior to the date the claimant purchased this protection plan (see page 1 for date of purchase)? If so, please provide exact dates and details:

_____

_____

_____

Any false or misleading statements made in support of and resulting in the payment of a claim shall be subject to legal action for collection of damages to the insurance company against the person or persons making such false and / or misleading statements.

Date Completed: _____ Physician's Signature: _____

Taxpayer ID Number: _____

### 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 Travel 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.

Date: _____ Signature: _____

(Signature of Person Suffering Illness or Injury or legally authorized representative)

## DOCUMENTATION REQUIREMENTS:

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.

____ Copies of cancelled checks or credit card statements that shows all payments made for the trip with an invoice from your Travel Provider showing the total cost paid for the trip.

____ Proof of Cancellation/Refund from travel supplier

____ Airline Ticket Stub/Receipt (if applicable)

____ Police Report (if applicable)

____ Car Rental Agreement (if applicable)

____ 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.

____ Other (please describe):_____

____ Please advise if you wish to be contacted via e-mail or regular mail_____

## OTHER INSURANCE / AUTHORIZATION:

Do you have any other type of insurance?_____

If so, please provide the Company Name and Address:_____

Type of Policy: _____Policy #: _____Contact: _____Phone: (_____)_____

I UNDERSTAND that it is illegal to knowingly file a false or fraudulent claim or to knowingly help someone else file one. I have read and understand the Fraud Notices on page 7 of this document.

_____ _____

Signed Date

**CLAIM INSTRUCTIONS:**

Send this form and any accompanying documentation to:

AXA Assistance USA
On Behalf of Nationwide Mutual Insurance Company and Affiliated Companies
P.O. Box 26222
Tampa, FL 33623

Or, E-mail your information to: AXAClaims@cbpinsure.com
Phone: 888-957-5015 / 727-412-7377

# CONSENT TO RECEIVE ALL COMMUNICATIONS ELECTRONICALLY

Please be advised, our preferred method of communication with you is electronically by email. Use of email helps us provide better and faster service. Please provide your consent to this in the area below. We will keep this on file with your claim.

**********

**EXPRESSED CONSENT TO RECEIVE ALL COMMUNICATIONS ELECTRONICALLY:**

## I AGREE TO RECEIVE ALL MAILINGS AND COMMUNICATIONS ELECTRONICALLY.

## I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THE ELECTRONIC DELIVERY*

## I ACCEPT ____ (please write in YES OR NO)

**Please confirm the preferred Email address in clear print below:**

**ENTER Email Address Here:**

**********

***CLICK THE TERMS AND CONDITIONS ABOVE TO REVIEW ONLINE,**
**OR DOWLOAD A COPY BY TYPING THE BELOW URL INTO YOUR INTERNET BROWSER:**

http://policydocuments.tpaproducts.com/EDOD/consent.pdf


NATIONWIDE® HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") applies to Nationwide[1] and describes the legal obligations of Nationwide, and your legal rights regarding your protected health information held by Nationwide under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Among other things, this Notice describes how your Protected Health Information ("PHI" as that term is defined below) may be used or disclosed to carry out treatment, payment, or healthcare operations, or for any other purposes that are permitted or required by law.

Nationwide is required by HIPAA and certain state laws to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice so long as it remains in effect. Nationwide reserves the right to change the terms of this Notice and to make the new Notice effective for all PHI maintained by us, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of the revised Notice by mail to your last-known address on file.

Protected Health Information (PHI) includes individually identifiable health information that is created or received by Nationwide and that relates to: (1) your past, present, or future physical or mental health or condition, (2) the provision of health care to you, or (3) the past, present, or future payment for the provision of health care to you. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Your Authorization. Certain uses and disclosures of PHI require your authorization. For example, most uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI require a written authorization. Except as outlined below, we will not use or disclose your PHI without your written authorization. If you have given us an authorization, you may revoke it in writing at any time, unless we have already acted on the authorization. Once we receive your written revocation, it will only be effective for future uses and disclosures.

Disclosures for Treatment, Payment or Health Care Operations. We may use or disclose your PHI as permitted by law for your treatment, payment, or health care operations. For instance, for your treatment, a doctor or health facility involved in your care may request information we hold in order to make decisions about your care. For payment, we may disclose your PHI to our pharmacy benefit manager for administration of your prescription drug benefit. For health care operations, we may use and disclose your PHI for our health care operations, which include responding to customer inquiries regarding benefits and claims.

Family and Friends Involved In Your Care. With your approval, we may from time to time disclose your PHI to designated family, friends, and others who are involved in your care or in payment for your care in order to facilitate that person's involvement in caring for you or paying for your care.

If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited PHI with such individuals without your approval.

[1] Nationwide Life Insurance Company®, National Casualty Company and the area within Nationwide Mutual Insurance Company® that performs healthcare functions.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. At times it may be necessary for us to provide your PHI to one or more of these outside persons or organizations. For example, we may disclose your PHI to a business associate to administer claims or to provide support services. In all cases, we require these business associates by contract to appropriately safeguard the privacy of your information.

Other Health-Related Products or Services. We may, from time to time, use your PHI to determine whether you might be interested in or benefit from treatment alternatives or other health-related programs, products, or services which may be available to you as a member of the health plan. For example, we may use your PHI to identify whether you have a particular illness and advise you that a disease management program to help you manage your illness better is available to you. We will not use your information to communicate with you about products or services which are not health-related without your written permission.

Plan Administration. We may release your PHI to your plan sponsor for administrative purposes, provided we have received certification that the information will be maintained in a confidential manner and not used in any other manner not permitted by law.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your PHI without your authorization. We may release your PHI for any purpose required by law. This may include releasing your PHI to law enforcement agencies; public health agencies; government oversight agencies; workers compensation; for government audits, investigations, or civil or criminal proceedings; for approved research programs; when ordered by a court or administrative agency; to the armed forces if you are a member of the military; and other similar disclosures we are required by law to make.

OTHER PRIVACY LAWS AND REGULATIONS

Certain other state and federal privacy laws and regulations may further restrict access to and uses and disclosures of your personal health information or provide you with additional rights to manage such information. If you have questions regarding these rights, please send a written request to your designated contact as explained in the "Contact Information" section, below.

RIGHTS THAT YOU HAVE

Access to Your PHI. You have the right to copy and/or inspect much of the PHI that we retain on your behalf. All requests for access must be made in writing and signed by you or your personal representative. We may charge you a fee if you request a copy of the information. The amount of the fee will be indicated on the request form. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Amendments to Your PHI. You have the right to request that the PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. If the information is incorrect or incomplete and we decide to make an amendment or correction, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. A request form can be obtained by writing to your designated contact at the address provided in the "Contact Information" section.

Accounting for Disclosures of Your PHI. You have the right to receive an accounting of certain disclosures made by us of your PHI. Requests must be made in writing and signed by you or your personal representative. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Restrictions on Use and Disclosure of Your PHI. You have the right to request restrictions on some of our uses and disclosures of your PHI. We will consider, but are not required to agree to, your restriction request. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Request for Confidential Communications. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your PHI information from us by alternative means or at alternative locations. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Right to be Notified of a Breach. You have the right to be notified in the event we discover a breach of your unsecured PHI.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice, even if you have requested such copy by e-mail or other electronic means.

Complaints. If you believe your privacy rights have been violated, you can file a written complaint with your designated contact as explained in the "Contact Information" section, below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights, in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

CONTACT INFORMATION

If you have any questions about this Notice, need copies of any forms or require further assistance with any of the rights explained above, contact us by calling 1-800-753-1000, x329 or mail your request to:

Co-ordinated Benefit Plans, LLC.
Attn: Privacy Officer
18167 US Highway 19 North
Suite 180
Clearwater, FL 33764

EFFECTIVE DATE

This Notice is effective 9/15/2015



NH-0524-H-09152015

## FRAUD STATEMENTS – If you reside in the state of:

**General:** 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.

**District of Columbia:** 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.

**Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a 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 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.

**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.

**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

**Louisiana:** 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.

**Missouri:** An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

**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.

**Puerto Rico:** Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

**Washington:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."

**All Other States:** 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/or civil penalties.