iTravelInsured Baggage Delay/Loss Claim Form

Please print legibly and complete ALL SECTIONS (front and back) of this application. Send this form by secure methods only.
Address: International Medical Group, Travel Claims, PO Box 241853, Apple Valley, MN 55124
Call: 1.866.243.7524 or 1.317.655.9798; **Fax:** +1.317.927.6882
Email: iTravelClaims@imglobal.com
www.imglobal.com

To report a loss, return the required documentation, along with your original signed claim form to IMG® Claims.
A delay in the processing of the claim will occur if unacceptable proof of loss or an incomplete claim form is submitted. Proof of loss must be submitted within 90 days of the date of loss. IMG reserves the right to obtain further information needed to determine eligibility for benefits and the proper payee.

BAGGAGE DELAY/LOSS - REQUIRED DOCUMENTATION

- ☐ Travel Itinerary
  A copy of the original itinerary reflecting the ticket number(s), date, and time(s) of the trip
- ☐ Refund
  A copy of all documents that reflect amounts paid to you for the delay/loss
- ☐ Items
  Provide a detailed list of the items lost, stolen, or damaged in the appropriate section of this form
- ☐ Receipts
  Original receipts for items purchased resulting from delay. Original receipts are needed for items lost, stolen or damaged beyond repair. Proof of ownership must be submitted if original receipts are not available
- ☐ Incident Report
  An irregularity report, incident report, or a copy of the initial loss report filed with the common carrier
- ☐ Police Report
  A copy of the police report is required for items stolen
- ☐ Settlement Statement
  A copy of the finalized settlement statement from the entity (e.g. airline, cruise line, tour operator, home insurance, credit card, etc.) that received the incident report
- ☐ Damage Baggage Verification
  A repair estimate or documentation from the entity making repairs. The repair estimate/documentation must be on entity's stationary

Benefits will not be paid for which you have already been reimbursed from another source or for any services which have been provided by the common carrier, hotel, or travel supplier, nor will benefits be paid for loss of damage to property covered under any other insurance.

PRIMARY CLAIMANT INFORMATION

Insured's Name *(Last, First, Middle)*:	Policy Number:
Complete Address:	
Email Address:	
Cell Phone Number *(With area code)*:	

Please note: by providing an email address and cell phone number on this form, you agree to electronic communications (including emails and SMS) about any claims that you have submitted.

PART 1. GENERAL INFORMATION

1. Full Name of Claimant: *(If additional travelers, please attach a separate sheet)*	Date of Birth: ___/___/___ *(MM/DD/YYYY)*
Policy Number:	Relationship to Insured:
2. Full Name of Claimant:	Date of Birth: ___/___/___ *(MM/DD/YYYY)*
Policy Number:	Relationship to Insured:
3. Full Name of Claimant:	Date of Birth: ___/___/___ *(MM/DD/YYYY)*
Policy Number:	Relationship to Insured:
4. Full Name of Claimant:	Date of Birth: ___/___/___ *(MM/DD/YYYY)*
Policy Number:	Relationship to Insured:

Name of Travel Supplier *(e.g. cruise line, airline, etc.)*:		
Travel Agency's Full Name:	Travel Agent's Name:	Telephone Number *(With area code)*:
Travel Agency's Mailing Address:		Email Address:

Please check the box for benefits requested: ☐ Baggage Delay ☐ Baggage Loss

PART 2. EXPLANATION OF DELAY/LOSS

Describe in detail what occurred:

Date of Delay/Loss: ___/___/___ *(MM/DD/YYYY)*	Time of Delay/Loss:	Location of Delay/Loss *(City, State, Country)*:
Date Baggage Returned: ___/___/___ *(MM/DD/YYYY)*	Length of Baggage Delay *(Days/Hours)*:	Total Baggage Delay/Loss Expenditures:

Did you receive compensation from any other party? ☐ Yes ☐ No If yes, the amount and payor: $

PART 3. SCHEDULE OF EXPENDITURES. Attach additional sheets if necessary.

Description of Item(s) Purchased	Date & Place of Purchase *(MM/ DD/YYYY)*	Cost *(List currency)*
	Total Amount Claiming:	

Receipt Reminder: *Original receipt(s) are needed. Proof of ownership must be submitted if original receipts are not available.*

PART 5. OTHER COVERAGE

Do you have any other insurance coverage related to the loss *(e.g. Domestic Health Insurance, Travel, Homeowners, etc.)*?	☐ Yes ☐ No
Do you have any other travel insurance coverage?	☐ Yes ☐ No
Did you report the loss to any other insurance company?	☐ Yes ☐ No

If Yes, which company:

Name of Company:	Policy/Certificate Number:	Telephone Number *(with area code)*:	Website:
1. _____ Address: _____ _____	_____	_____	_____
2. _____ Address: _____ _____	_____	_____	_____
3. _____ Address: _____ _____ *(Please attach a separate sheet if necessary)*	_____	_____	_____

CLAIM FORM FRAUD STATEMENT
FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

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.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ALASKA and KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

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.

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.

FLORIDA: WARNING: 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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 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.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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.

OKLAHOMA: Any person who knowingly, 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.

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

TEXAS: Any person who knowingly presents a 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.

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.

AUTHORIZATION

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.

A delay in the processing of this claim may occur if unacceptable proof of loss or an incomplete claim form is submitted. Proof of loss must be submitted within 90 days of the date of loss. IMG reserves the right to obtain further information needed to determine eligibility for benefits and the proper payee.

The undersigned represents and warrants information or documents provided to IMG by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees:

1) Any insurance coverage or benefit is contingent upon any statement made to IMG as being complete and correct.
2) Benefits under the terms and conditions of the insurance contract will be paid only if IMG determines the applicant is entitled to them.
3) By providing an email address and cell phone number on this claim, you agree to electronic communications (including emails and SMS) about any claims that you have submitted.

Signature of Insured/Claimant 1:	Date: ___/___/___ *(MM/DD/YYYY)*
Signature of Insured/Claimant 2:	Date: ___/___/___ *(MM/DD/YYYY)*
Signature of Insured/Claimant 3:	Date: ___/___/___ *(MM/DD/YYYY)*
Signature of Insured/Claimant 4:	Date: ___/___/___ *(MM/DD/YYYY)*