P.O. Box 88503
Indianapolis, IN 46208-0503
T: (866) 243-7524
(317) 655-9798
F: (317) 655-4505

TRAVEL DELAY CLAIM FORM

Instructions: Failure to supply complete information may delay your claim process!

1. Complete all information requested below.
2. Attach a copy of documentation from the airline, railroad, cruise line or other common carrier providing the reason for the delay and the length of delay.
3. Attach a copy of original ticket or itinerary and a copy of final ticket or itinerary showing departure dates and times.
4. Attach legible copies of itemized receipts for purchase of essential items, lodging or meals.
5. Attach copies of carrier lodging or meal vouchers (if any).
6. Send this in along with your completed and signed Travel Delay Claim Form.

Information about You and Your Claim

Name of Insured person and all persons traveling with you covered under this policy:

1)_____ Date of Birth: ____/____/____

2)_____ Date of Birth: ____/____/____

3)_____ Date of Birth: ____/____/____

4)_____ Date of Birth: ____/____/____

Present Address:_____

City, State, and Zip:_____

Home Telephone: _____ **Work Telephone**:_____

Name and telephone of Travel Agency from whom you purchased your trip:

_____

Your Scheduled Departure Date: _____**Your Scheduled Return Date**:_____

Your Travel Insurance Certificate #: _____
(This is on your travel insurance receipt)

1. What caused your delay? _____

_____

_____

_____

_____

(Please attach a copy of all vouchers or payments received from the common carrier compensating your delay)

2. Date and time of original departure? _____

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3. Date and time of actual departure? _____

4. Did you receive any compensation from the carrier? No___ Yes ___ if yes, amount? $_____

To calculate your claim:

# of 24-hour periods: _____ (i.e. 1, 2 etc.)
(See Date and Time of Scheduled vs. Actual Departure in #s 2 & 3 above to calculate # of 24 hour periods).

Total Expenditures for Delay: $_____

Less: Payment by Carrier: - _____

Total Out-of-Pocket Loss: $_____/_____ = $_____/per day
(Total $ Loss) divided by (# of 24-hour days)

Remember, the claim is limited to a fixed amount for each 24-hour period!

I/We attest that all the information submitted is true and accurate to the best of our knowledge. Furthermore, I/We agree that this insurance shall be void if, whether before or after the loss/incident, any person has concealed or misrepresented any fact or circumstance concerning this claim. The signatures of all parties that are party to this claim appear below

_____ _____
(Signature of Claimant) (Date: mm/dd/yyyy)

_____ _____
(Signature of Claimant) (Date: mm/dd/yyyy)

Please mail your completed, signed form back to the claims administrator along with all of your documentation. The documentation is your proof of loss and is required in order to finalize your claim.