

TLC CLAIM FORM

IMPORTANT: Please read this form carefully. If this form is not fully completed and appropriate documentation provide, it may delay the handling of your claim.

PLEASE NOTE: For claims involving illness, injury, or death, the Physician's Statement must be completed. A doctor's note is not sufficient. Certain "pre-existing" conditions, as defined in your policy may not be covered under Lodging Cancellation, Lodging Interruption and Travel Delay. Please read your policy carefully.

SECTION 1 – PROTECTED PARTY INFORMATION

Name of Protected _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Email Address _____ Telephone Number _____

Name of Co-Protected/Traveling Companion _____

SECTION 2 – TRAVEL INFORMATION

Booking/Reservation Number _____ Departure Date _____ Return Date _____ Trip Cost _____

SECTION 3 – DETAILS OF LOSS

Reason for Lodging Cancellation, Lodging Interruption or Travel Delay _____

Date of Lodging Cancellation, Lodging Interruption or Travel Delay _____

Who did you notify and when? _____

SECTION 4 – DETAILS OF SICKNESS OR INJURY – If Applicable

Name of Patient _____ Relationship of Patient to Named Protected _____

Nature of Sickness _____ Date Sickness First Began _____ Date First Treated _____

Were you treated for this condition prior to the purchase of this Protection Plan?

Yes No If "Yes" please list dates. _____

Nature of Injury _____ Date and Time of Incident _____ How and Where Did Accident Occur _____

Was an Accident Report Completed for this incident?

Yes No If "Yes" please enclose a copy. _____

SECTION 5 – PHYSICIAN’S STATEMENT (TO BE COMPLETED BY PHYSICIAN ONLY)

In order to process this benefit request for your patient, we will need this section fully completed. If questions are unanswered when we receive it, we may write to you in order to obtain additional information, and it may delay processing of the claim.

Full Name of Patient _____ Date of Birth _____

This Treatment is the Result of: _____ Diagnosis _____
O SICKNESS O INJURY

On what date did symptoms first appear? _____ On what date did the patient first consult with you? _____

Please list all dates of examination/treatments for this condition from initial consult to present _____

Has patient ever been treated for this or a related condition?
O YES O NO If “YES” give dates of treatment and diagnosis _____

Was Patient Referred By Another Physician? O YES O NO
If yes give Physician Info Name Address Telephone # _____

On what date did the patient become medically unable to travel? _____

Is this condition a complication of an underlying condition? O Yes or O No
If yes, please specify. _____

If Accident or Injury, please provide date, time and place of occurrence _____

How did accident occur? _____

Physician’s Signature and Degree _____ Tax ID/IRS# _____ Date _____

PLEASE TYPE OR PRINT THE FOLLOWING, OR PLACE YOUR STAMP BELOW:

Physician’s Name _____

Street Address _____ City _____ State _____ Zip Code _____

Telephone _____ Fax _____

SECTION 6 - COMMENTS

Use This Space for Any Additional/Clarifying Information That May Help Us Process Your Claim

PLEASE NOTE: Your Policy May Not Provide Coverage For Certain "Pre-Existing" Medical Conditions. Please Read Your Policy Carefully.

WARNING AND COMMENTS

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM OR APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL PENALTIES, FINES, AND/OR IMPRISONMENT.

CLAIMS PROVISIONS

1. Present all claims to:

TLC Travel Protection
PO BOX 790
Gatlinburg, TN 37738
877.563.9765

2. Written Proof of Loss must be sent to us within 90 days after the date the loss occurs. We will not reduce or deny a claim if it was not reasonably possible to give us written Proof of Loss within the time allowed.

3. At our expense, we have the right to have you examined as often as necessary while claim is pending.

4. No legal action may be brought to recover on the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 90 days from the time a determination by TLC Travel Protection, to accept or deny, has been made on the claim. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet time allowed by such law.

BY SUBMITTING THIS CLAIM, I CERTIFY THAT ALL ANSWERS TO THESE QUESTIONS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Protected's Signature

Date

Home Telephone

Business Telephone
