

**Travel Insured International, Inc.®**  
**Claims Department, P.O. Box 280568, East Hartford, CT 06128**  
 Phone: 1-866-890-6499 | Fax: 1-860-528-8005  
 Email: [claims@travelinsured.com](mailto:claims@travelinsured.com) | Web: [www.travelinsured.com](http://www.travelinsured.com)

## To be completed by the Planholder

Name of Planholder		Plan/Policy#	
Address		Work Phone # (     )	Work Phone # (     )
		E-mail Address	Date of Birth
Date of Initial Trip Deposit	Date incident occurred	Date cancelled/interrupted with Property Management Co.	
Scheduled Departure Date	Scheduled Return Date	Reservation #	E-mail Address
Name and Address of Property Management Co.		Phone # (     )	Fax # (     )

Name of Travel Companion(s)

**Complete the following and attach the required documentation (see page 2). Please print clearly.**

Please briefly explain your claim:


## Please complete below if cancellation/interruption is due to sickness or injury.

Name of Patient		Relationship to Planholder	
Give the nature of sickness or injury (Diagnosis)		Date symptoms first appeared	
If it was an accident resulting in injury was a report filed? ___ Yes ___ No If yes, please enclose a copy of report.		Date first seen by physician	
Were you treated for this condition prior to insurance purchase? ___ Yes ___ No If yes, when?			
If trip was cancelled due to death please provide copy of death certificate and relationship to Planholder.			
Name and address of family physician who first treated the condition		Physician's Phone # (     )	Physician's Fax # (     )
Name and address of other physician(s) who treated the condition and speciality		Physician's Phone # (     )	Physician's Fax # (     )
Name of Hospital (if hospitalized)	Date Admitted/Discharged	Hospital Phone # (     )	Hospital Fax # (     )

