



Please complete form by typing or printing clearly in ink and return to:  
 On Call International Claims Department  
 11 Manor Parkway – Salem, NH 03079  
**Ph: 855-878-9590**  
**Fax: 603-893-5264**  
**TPAClaims@oncallinternational.com**

A. PARTICIPANT INFORMATION		
Name	Date of Birth	Employee ID
Name of School or Employer	Social Security Number	Gender
Home address		
Member Phone Number	Member Email Address	

B. POLICY INFORMATION	
Policy Number	Policy Name
Effective date (MM/DD/YYYY)	Termination Date (MM/DD/YYYY)

C. TRIP INFORMATION		
Booking / Reservation Number	Scheduled Time and Date of Departure	Scheduled Time and Date of Return
Destination(s)	Actual Time and Date of Departure	Actual Time and Date of Return
If you are claiming for expenses related to the loss, delay or damage which occurred while insured property was on or in the custody of a common carrier (i.e. railroad, airline, steamship, bus, taxi, etc,) please name the common carrier below and attach your passenger ticket:		
If you have filed a claim against the common carrier, provide claim number, attach a copy of the report and provide the carriers response:		
Do you have any other Travel Insurance? Please provide name and address of the company:		

**The following sections may include benefits which are not included in your plan. Please review your policy documents and only complete information for benefits which you are eligible to claim for.**

D. CLAIM INFORMATION FOR:	
LOSS OF PERSONAL BELONGINGS	
LOSS OF CHECKED IN LUGGAGE	
LOST DOCUMENTS OR MONEY	
Describe circumstances of the loss or theft:	
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E. DETAIL CLAIMED EXPENSES				
Item	Description	Date of Loss	Locations of Loss	Amount Claimed

<b>E. CLAIM INFORMATION FOR:</b>	
LUGGAGE DELAY	
TRAVEL DELAY	
MISSED CONNECTION	
Describe Reason for Delay or Missed Connection:	
Date of Delay	Length of Delay

DETAIL CLAIMED EXPENSES				
Item or Expense Incurred	Description	Date Expense Incurred	Location Expense Incurred	Amount

<b>E. CLAIM INFORMATION FOR:</b>	
TRIP INTERRUPTION	
PRE-TRIP CANCELLATION	
Describe circumstances of Trip Interruption or Pre-Trip Cancellation:	



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<b>Date Interruption of Cancellation Occurred</b>	<b>Date of Initial Trip Deposit (Cancellation claims only)</b>
<b>If the reason for interruption or cancellation was medical in nature, complete the following section:</b>	
<b>Name of the Patient</b>	<b>Relation to the Insured Person (if applicable)</b>
<b>Date symptoms first appeared</b>	<b>If claim is the result of an Accident, was there a police report filed? Identify the Police Dept:</b>
<b>Name of Hospital (if applicable)</b>	<b>Date First seen by a Physician</b>
<b>Hospital Phone</b>	<b>Dates admitted and discharged</b>

<b>DETAIL CLAIMED EXPENSES</b>				
<b>Item or Expense Incurred</b>	<b>Description</b>	<b>Amount Paid</b>	<b>Amount Refunded</b>	<b>Amount Claimed</b>

<b>F. PAYMENT INFORMATION</b>	
<b>Make payment to the Primary Insured at the address in Section A</b>	
<b>Make payment to the primary insured at address below</b>	
<b>Address:</b>	
<b>Make payment to primary insured to this receiving bank:</b>	
<b>Name of Receiving Bank</b>	<b>Phone of Receiving Bank</b>
<b>Address of Receiving Bank</b>	<b>Account Number</b>
<b>Name on Account</b>	<b>ABA Routing # (if applicable)</b>
<b>SWIFT Code for Receiving Bank</b>	<b>IBAN # (if applicable)</b>



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**G. SIGNATURE**

**AUTHORIZATION:** I hereby authorize On Call International or its representative, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, x-rays, and any other data necessary to determine eligibility of benefits. I also authorize On Call International or its representative to release and share claim information including that which may be used in the identification and prevention of potential fraudulent activity to any insurance support organization, fraud information clearinghouses, designated service providers and business associates assisting in the processing of this claim. A photostatic copy or facsimile of this authorization shall be deemed as effective and valid as the original. This authorization is valid for twelve (12) months from date of signature.

**Signature of Insured Person:**

Date

**H. INSTRUCTIONS FOR FILING A CLAIM**

In order to complete your claim, follow these steps.

**Please note that sending an incomplete form will result in a delay of processing your claim.**

- Submit a separate claim for each Insured Person
- Claims must be submitted with appropriate documentation required by your policy.
- All bills must be itemized – canceled check, cash register receipts and ‘balance due’ statements cannot be processed
- An itemized bill is a full description of all actual charges.
- Payments are made to the Primary Insured Member on the plan. Payments cannot be made directly to a dependent or to a third party.
- If paying an international provider, the invoice must include bank information.



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## IMPORTANT NOTICE

**Fraud Warning:** Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application of files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

**Notice to Arizona Claimants:** 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.

**Notice to California Claimants:** For your protection California law requires the following to appear on this form. Any person who knowingly presents 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.

**Notice to Colorado Claimants:** It is unlawful to knowingly provide false, incomplete, or misleading 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 policy holder of claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or aware payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Notice to Hawaii Claimants:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

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

**Notice to Kentucky Claimants:** 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.

**Notice to Oklahoma Claimants:** Warning: 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.

**Notice to Pennsylvania Claimants:** 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.

**Notice to Texas Claimants:** 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.