

## Section 1: To be completed by claimant/insured

### About the Claimant

|                                    |                     |              |
|------------------------------------|---------------------|--------------|
| Name of Claimant/Insured           |                     | Claim Number |
| Address (street, city, state, zip) |                     |              |
| Date of Birth                      | Trip Departure Date | Policy Date  |
| Email Address                      |                     |              |

### About the Patient - Complete only if different from Insured

|                                     |             |                                    |
|-------------------------------------|-------------|------------------------------------|
| Name of Patient                     |             | Date of Birth                      |
| Was patient traveling with insured? | Yes      No | Relationship of Patient to Insured |

### Authorization to Disclose Information

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Arch insurance Company, or it's authorized representative. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past.

The company will use this information to determine if any claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigation or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization.

I certify that the information given by me in support of my claim is true and correct. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution or insurance fraud.

|  |  |      |
|--|--|------|
| Patient's or Authorized Representative's Signature | If Authorized Representative, Relationship to Patient or Legal Designation | Date |
|--|--|------|

## Section 2: To be completed by physician

### About the Diagnosis and Treatment

|  |   |  |
|--|---|--|
| Diagnosis / ICD Code (primary diagnosis)   |   |  |
| Diagnosis / ICD Code (secondary diagnosis)   |   |  |
| What are the patient's symptoms?   | Date symptoms first appeared?               |  |
| Date patient first consulted you for this condition?   | Date of positive covid test, if applicable? |  |
| Has the patient ever had this condition before?  | Yes      No                                 | If yes, prior dates of treatment?      |
| Is this condition an exacerbation or a complication of an existing condition?  | Yes      No                                 | If yes, when did the condition worsen? |
| If the patient was referred <b>from or to</b> another physician, name and phone number of that physician?                |   |  |
| Dates of medical visits as they relate to the condition causing the trip cancellation/interruption.<br>Date(s) of visit? | Was the patient seen for a physical exam?   | Yes      No                            |
| Is the patient hospitalized or have they been in the past 12 months for this condition or related conditions?            |   | Yes      No                            |
| If yes, Name & Location of Hospital?   |   |  |
| Dates of Hospitalization?  |   |  |

## Section 2, continued: To be completed by physician

### About the Medical Condition as it relates to Travel

|  |   |
|--|---|
| On what date did you advise the patient that he/she was disabled and unable to travel?   |   |
| Explain in detail reasons for restrictions that would prevent your patient's travel on date of departure.  |   |
| What date did you advise the patient that he/she would be able to travel again? If you did not provide a date, what is a reasonable time frame within which the patient is expected be able to travel?                               |   |
| If the patient was non-traveler, did you advise the Traveler to cancel or interrupt the trip due to the <b>non-traveler's</b> medical condition? <div style="float: right; text-align: right;">           Yes      No         </div> |   |
| If yes, please explain:  | If no, on what date was it reasonable for the patient/insured to cancel/interrupt their trip? |
| Date you advised Traveler to cancel trip:  |   |

### Physician Information and Signature

Please note: All of the above requested information is necessary for the processing of the Claimant's claim. Any omitted items will delay processing.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable by law.

If this form is completed by a Nurse Practitioner, kindly include a Supervising Physician's signature where required by state regulations.

I have read the foregoing, and the above answers are true and complete according to the best of my knowledge and belief.

|  |            |      |
|--|------------|------|
| Physician's Signature  |            | Date |
| Physician's Name   |            |      |
| License Number   | Specialty  |      |
| Phone Number   | Fax Number |      |
| Affiliated Medical Facility Information, if applicable<br>Facility Name & Location |            |      |



**Phone No:** 1-877-722-1959  
**Fax:** 1-443-279-2901  
**Email:** [claims@archinsurancesolutions.com](mailto:claims@archinsurancesolutions.com)  
**File a claim online at**



**Phone No:** 1-855-762-6252  
**Fax:** 1-443-279-2901  
**Email:** [claims@roamright.com](mailto:claims@roamright.com)  
**File a claim online at**



**Phone No:** 1-866-889-7409  
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**Email:** [redsky@archinsurance.com](mailto:redsky@archinsurance.com)  
**File a claim online at**