Attending Physician's Statement

Claims Department: Red Sky Claims, C/O Arch Insurance Company
Executive Plaza IV, 11350 McCormick Road, Suite 102, Hunt Valley, MD 21031

Phone No: 1-844-800-2486 | **Fax:** 443-279-2901 | **Email:** redsky@archinsurance.com

Section 1: To be completed by claimant/insured

About the Claimant

Name of Claimant/Insured			Policy Number
Address (street, city, state, zip)			
Gender Male ☐ Female ☐	Date of Birth	Trip Departure Date	Policy Purchase Date

About the Patient - Complete only if different from Insured

Name of Patient	
Was patient traveling with insured? Yes ☐ No ☐	Relationship of Patient to Insured

Section 2: To be completed by physician

About the Diagnosis and Treatment

Diagnosis / ICD-9 Code (primary diagnosis)	
Diagnosis / ICD-9 Code (secondary diagnosis)	
Date symptoms first appeared	Date patient first consulted you for this condition
Has the patient ever had this condition before? Yes ☐ No ☐	If yes, when?
Is this condition an exacerbation or a complication of an existing condition? Yes ☐ No ☐	If yes, what was that condition?
If the patient was referred **from** another physician, name and phone number of that physician	
If the patient was referred **to** another physician, name and phone number of that physician	

Dates of medical visits as they relate to the condition causing the trip cancellation/interruption.

Date of consultation	Describe Condition/Treatment

Has the patient been hospitalized for this condition or related conditions in the past 12 months? Yes ☐ No ☐	If yes, date of admittance and date of discharge?

About the Medical Condition as it relates to Travel

Was the Insured/Traveler unable to travel on the policy purchase date listed in Section 1 above?	Yes ☐ No ☐
If the patient was Traveler, did you advise patient to cancel or interrupt the trip due to the medical condition?	Yes ☐ No ☐
If yes, please explain: Date you advised patient to cancel trip:	If no, on what date was it reasonable for the patient/insured to cancel/interrupt their trip?

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Executive Plaza IV, 11350 McCormick Road, Suite 102, Hunt Valley, MD 21031

Phone No: 1-866-889-7409 | **Fax:** 443-279-2901 | **Email:** redsky@archinsurance.com

Section 2, continued: To be completed by physician

About the Medical Condition as it relates to Travel, continued

If the patient was non-traveler, did you advise the Traveler to cancel or interrupt the trip due to the non-traveler's medical condition?	Yes ☐ No ☐
If yes, please explain: Date you advised Traveler to cancel trip:	If no, on what date was it reasonable for the patient/insured to cancel/interrupt their trip?
If the condition was related to pregnancy, when was the pregnancy first diagnosed?	If related to pregnancy, expected delivery date
Was the patient hospitalized while traveling? Yes ☐ No ☐	Was this an emergency room admission? Yes ☐ No ☐
Name & Location of Hospital	
Date Admitted	Date Discharged

Physician Information and Signature

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

Please attach copies of the patient's office records for the 6 months prior to the trip departure date.

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.

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