Arch Red Sky℠

Ski Pass Cancellation / Interruption Claim Form

SKI PASS PRESERVER

Claims Department:
Red Sky Claims, C/O Arch Insurance Company
Executive Plaza IV, 11350 McCormick Road, Suite 102, Hunt Valley, MD 21031 United States
Toll Free Phone: (844) 800-2486 | **Fax:** (443) 279-2901 | **E-mail:** redsky@archinsurance.com

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Arch Insurance Company®
Powering Specialty Risk Solutions®

To be completed by the Insured / Guest

Name of Insured / Guest			Transaction ID #
Address		Work Phone #	Home Phone #
		E-mail Address	Date of Birth
Date of Ski Pass Purchase	Date Incident Occurred	Date Ski Pass Cancelled / Interrupted	Effective Date of Cancellation
Ski Pass Start Date	Ski Pass End Date	Name of resort Ski Pass was purchased with:	
Was a credit issued for cancellation of the ski pass? ☐ Yes ☐ No	If yes, what was the amount of the credit?	Do you intend on using the credit? ☐ Yes ☐ No	
Complete the following and attach the documentation of your Ski Pass purchase and cancellation. Please briefly explain your claim.			

To be completed by Insured / Guest if claim is due to sickness or injury

Name of patient		DOB (mm/dd/yy)	
Date symptoms first appeared (mm/dd/yy)	Date first seen by physician (mm/dd/yy)	Did accident resulting in injury involve a motor vehicle? ☐ Yes ☐ No	
If yes, please list the names of all involved parties, insurance carriers, and policy numbers.			
Was a police report filed? ☐ Yes ☐ No	If yes, please identify the Police Department where it was filed.		
Was the patient treated for this condition prior to insurance purchase? ☐ Yes ☐ No		If yes, when?	
If trip was cancelled due to death, please provide a copy of death certificate and relationship to Insured / Guest.			
Name & address of family physician who first treated the condition		Physician's Phone #	Physician's Fax #
Name & address of primary care physician where patient resides		Physician's Phone #	Physician's Fax #
Name & address of other physician(s) who treated the condition and specialty		Physician's Phone #	Physician's Fax #
Name of Hospital (if hospitalized)	Date(s) Admitted & Discharged	Hospital Phone #	Hospital Fax #

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Authorization to Disclose Information

Ski Pass Preserver Product is Underwritten by **Arch Insurance Company.**
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 its 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. To any insurance company, any travel organization or agency, airline carrier, cruise line, your operator, rental agency, hotel, motel, or similar entity providing lodging on a rental / lease basis or any other person who may have knowledge regarding this claim: I authorize the release any information required regarding this claim and the loss reported.

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 effect 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 _____ **Date** _____

If Authorized Representative, Relationship to Patient _____

or Legal Designation _____

Attending Physician's Statement

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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 **from or 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(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 **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?

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 Facility Name & Location	