



# Ski Pass Cancellation / Interruption Claim Form

**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.



## 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what was the amount of the credit?	Do you intend on using the credit? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please list the names of all involved parties, insurance carriers, and policy numbers.			
Was a police report filed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please identify the Police Department where it was filed.		
Was the patient treated for this condition prior to insurance purchase? <input type="checkbox"/> Yes <input type="checkbox"/> 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 #

**Continued on next page →**



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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



Claims Department: Red Sky Claims, C/O Arch Insurance Company, Executive Plaza IV, 11350 McCormick Road, Suite 102, Hunt Valley, MD 21031  
Toll Free Phone: (866) 889-7409 (US) (844) 800-2486 (Canada) | Fax: (443) 279-2901 | E-mail: redsky@archinsurance.com

## 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

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

Name of Patient		Date of Birth
Was patient traveling with insured?	Yes <input type="checkbox"/> No <input type="checkbox"/>	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
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## For COVID-19 Related Treatment Proceed Directly To Section 3

## Section 2: To be completed by physician

### About the Diagnosis and Treatment (for non-COVID-19 related claims)

Diagnosis / ICD Code (primary diagnosis)	
Diagnosis / ICD Code (secondary diagnosis)	
Date symptoms first appeared	Date patient first consulted you for this condition
Has the patient ever had this condition before? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, prior dates of treatment?
Is this condition an exacerbation or a complication of an existing condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	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. Date(s) of visit	Was the patient seen for a physical exam? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the patient hospitalized or have they been in the past 12 months for this condition or related conditions ? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, Name & Location of Hospital	
Dates of Hospitalization	



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

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

On what date was the Patient disabled and unable to travel?	
How long will the patient be unable to travel?	
Date you advised patient to cancel trip:	
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 <input type="checkbox"/> No <input type="checkbox"/>	If no, on what date was it reasonable for the patient/insured to cancel/interrupt their trip?
If yes, please explain:	
Date you advised Traveler to cancel trip:	

### Section 3: To be completed by physician for COVID-19 positive patient

#### About the Diagnosis and Treatment of Your Patient (for COVID-19 related claims)

Diagnosis / ICD Code (primary diagnosis)	
Diagnosis / ICD Code (secondary diagnosis)	
Is patient symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe all symptoms:
Date patient first consulted you for this condition	Was the first consult in person or via Teledoc? <input type="checkbox"/> In Person <input type="checkbox"/> Teledoc
Date(s) of positive COVID test(s) and type of test(s):	
Provide all dates of medical visits as they relate to the condition causing the trip cancellation/interruption. Date(s) of visit	
Was the patient hospitalized for COVID-19 or related conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, provide the Name & Location of Hospital	
Dates of Hospitalization	

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

Were your patient's COVID symptoms so disabling that they are unable to travel on date of departure? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain in detail the reasons for restrictions that would prevent your patient's travel on date of departure.
Please list the date you advised patient to cancel the trip due to the above stated reasons.
If your patient was not scheduled to travel with the Claimant, did you advise the Claimant to cancel or interrupt the trip due to your patient's medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain why you so advised:
Date you so advised the Claimant to cancel trip:



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### 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.

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		

## State Notices

The laws of some states require us to furnish you with the following notices:

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<b>Alabama</b>	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.
<b>Alaska</b>	A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
<b>Arizona</b>	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.
<b>Arkansas</b>	Any person who knowingly presents a false or fraudulent claim for payment of a 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.
<b>California</b>	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.
<b>Colorado</b>	It is unlawful to knowingly provide false, incomplete, or misleading facts or 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
<b>Delaware</b>	Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
<b>District of Columbia</b>	WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
<b>Florida</b>	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
<b>Idaho</b>	Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

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<b>Indiana</b>	A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
<b>Kentucky</b>	Any person who knowingly and with intent to defraud any insurance company or other person files a 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.
<b>Louisiana</b>	Any person who knowingly presents a false or fraudulent claim for payment of a 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.
<b>Maine</b>	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
<b>Maryland</b>	Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
<b>Minnesota</b>	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
<b>New Hampshire</b>	Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
<b>New Jersey</b>	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
<b>New Mexico</b>	ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
<b>New York</b>	<p>Auto claims: Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.</p> <p>All others: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.</p>

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<b>Ohio</b>	Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
<b>Oklahoma</b>	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.
<b>Oregon</b>	Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.
<b>Pennsylvania</b>	Motor vehicles: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000.  All others: 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.
<b>Rhode Island</b>	Any person who knowingly presents a false or fraudulent claim for payment of a 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.
<b>Tennessee</b>	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
<b>Texas</b>	Any person who knowingly presents a 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.
<b>Utah</b>	Workers' Compensation Claims Only: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.
<b>Virginia</b>	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
<b>Washington</b>	It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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**West Virginia** Any person who knowingly presents a false or fraudulent claim for payment of a 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.

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**Puerto Rico** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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