



Trip Delay 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		Reservation #
Address	Work Phone #	Home Phone #
	E-mail Address	Date of Birth
Scheduled Departure Date	Scheduled Return Date	Date Delayed (mm/dd/yy)
Name and Address of Property Management Company		Fax #
Name of leaseholder on the rental property and list all guests occupying the property		
Please Briefly explain your claim:		
Is there any other insurance that provides coverage for this loss (homeowners, renters, credit card, other travel insurance)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please provide name of insurance company, policy number, and address		

Please check the box which applies to your claim

- Additional accommodation and meal expenses Amount being claimed: _____
- Additional Transportation Expenses Amount being claimed: _____
- Prepaid, Unused non-refundable land and water accommodation trip costs Amount being claimed: _____

Please supply the following items based on which box you've checked.

- ✓ If delay is due to a common carrier delay, please provide us with written verification from the common carrier as to the cause and length of your delay. Please include your flight itinerary or ticket copies from your common carrier. If not, provide documentation verifying the cause of delay.
 - For additional Accommodation Expenses:
 - Please provide us with proof of payment for additional accommodations and meal expenses (invoices or receipts and a copy of your canceled check or credit card statement showing payment for the additional expenses).
 - For additional Transportation Expenses:
 - Please provide us with proof of payment for additional transportation expenses (invoices or receipts and a copy of cancelled checks or credit card statement showing payment for the additional expenses).
 - For pre-paid, unused non-refundable land and water trip costs:
 - Please provide us with proof of payment for pre-paid, unused non-refundable land and water trip costs (invoices or receipts and a copy of cancelled checks or credit card statement showing payment for the additional expenses).
- ✓ If claimant is other than leaseholder, please provide a signed written statement from leaseholder listing all guests occupying the rental property.



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List all guests occupying the rental property

Guest Name:	Claiming trip delay? <input type="checkbox"/> Yes <input type="checkbox"/> No
Guest Name:	Claiming trip delay? <input type="checkbox"/> Yes <input type="checkbox"/> No
Guest Name:	Claiming trip delay? <input type="checkbox"/> Yes <input type="checkbox"/> No
Guest Name:	Claiming trip delay? <input type="checkbox"/> Yes <input type="checkbox"/> No
Guest Name:	Claiming trip delay? <input type="checkbox"/> Yes <input type="checkbox"/> No
Guest Name:	Claiming trip delay? <input type="checkbox"/> Yes <input type="checkbox"/> No
Guest Name:	Claiming trip delay? <input type="checkbox"/> Yes <input type="checkbox"/> No
Guest Name:	Claiming trip delay? <input type="checkbox"/> Yes <input type="checkbox"/> No
Guest Name:	Claiming trip delay? <input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Total expenses being claimed	

Authorization to Disclose Information

Trip 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 requested 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 _____