## Nationwide® Travel Insurance – Wanderwell
## Accident & Sickness Claim Form & Claimant's Statement

**PARTICIPANT'S INFORMATION**:

Plan Name: _____ Policy Certificate #: _____ (found on confirmation email)

| | Claimant Name | Insured ID | DOB | | Claimant Name | Insured ID | DOB |
|---|---|---|---|---|---|---|---|
| 1. | _____ | _____ | / / | 3. | _____ | _____ | / / |
| 2. | _____ | _____ | / / | 4. | _____ | _____ | / / |

Email Address: _____ Primary Phone #: (____)_____

Address: _____ City:_____ State:____ Zip Code:_____

Please advise if you wish to be contacted via e-mail or regular mail: _____

**TRAVEL INFORMATION**:

Date Travel Arrangements were made: ____/___/____ Date of initial payment deposit: ___/___/_____

Scheduled Date of Departure: ____/___/____ Scheduled Date of Return: _____/___/_____

**OTHER COVERAGE / AUTHORIZATION**:

Do you have any other type of coverage?_____

If so, please provide the Company Name and Address: _____

Type of Policy: _____ Policy #: _____ Contact: _____ Phone: (__) _____

Have you filed a claim with their office at this time? : ___Yes ___No

If yes, please note their response: _____

If not, why not: _____

**ILLNESS/ACCIDENT STATEMENT**:

Name of person having sickness or injury: _____ His / Her date of birth: ___/___/____

Date Sickness or Injury began: ___/___/_____ Date First Treated: _____/___/_____

Nature of Sickness or Injury (If Injury, describe accident, including date and place): _____

_____

_____

Period of hospitalization: From ___/___/_____ To: ___/___/_____ Date ended: ___/___/_____

Was there an accident report for this incident? _____ If Yes, please provide a copy.

Was there any previous treatment for this condition? ____ If Yes, please names of physician and dates of treatment:

_____

_____

_____

**EXPENSES CLAIMED:**

Please provide supporting documentation of the expenses you are claiming in addition to this claim form

| Name of Provider | Date Incurred | Amount of Bill | Amount Paid by Other Insurance | Amount Claimed |
|---|---|---|---|---|
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |

(please use Page 4 if you are claiming more items)

**TOTAL AMOUNT CLAIMED $_____**

**DOCUMENTATION REQUIREMENTS**:

Depending upon the circumstance involved in the loss, one or more of the following items may be required to complete the processing of your claim. Please place a check by those items you have attached. We recommend you keep copies of any items submitted with this claim.

- Copies of itemized bills and/or statement from medical providers for services rendered in connection with your claim. These bills and/or statements must include the date of service, the service rendered, the charge for each service, and the diagnosis.
- If you have other insurance, we need the final disposition from the primary insurer listing payment or denial of your claim with them (Explanation of Benefit or "EOB").
- Copies of the front and back of your canceled checks and/or your credit card statements showing your payments for the trip; and a copy of your trip invoice.
- Airline Ticket Stub/Receipt (if applicable)
- Copies of your credit card statements and/or cancelled checks showing your payment for the medical service submitted.
- If medical expenses were incurred abroad, attach copies of your passport pages which identify you as the traveler and document your entrance into and exit from the country or countries where medical services were received.
- Other (please describe): _____
- Please advise if you wish to be contacted via e-mail or regular mail _____

I UNDERSTAND that it is illegal to knowingly file a false or fraudulent claim or to knowingly help someone else file one. I have read and understand the Fraud Notices in this document.

_____ _____

Signed Date

## CONSENT TO RECEIVE ALL COMMUNICATIONS ELECTRONICALLY

Please be advised, our preferred method of communication with you is electronically by email. Use of email helps us provide better and faster service. Please provide your consent to this in the area below. We will keep this on file with your claim.

**********

**EXPRESSED CONSENT TO RECEIVE ALL COMMUNICATIONS ELECTRONICALLY:**

**I AGREE TO RECEIVE ALL MAILINGS AND COMMUNICATIONS ELECTRONICALLY.**

**I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THE ELECTRONIC DELIVERY***

**I ACCEPT ____ (please write in YES OR NO)**

**Please confirm the preferred Email address in clear print below:**

**ENTER Email Address Here:**

**********

***CLICK THE TERMS AND CONDITIONS ABOVE TO REVIEW ONLINE,**
**OR DOWLOAD A COPY BY TYPING THE BELOW URL INTO YOUR INTERNET BROWSER:**

http://policydocuments.tpaproducts.com/EDOD/consent.pdf

Underwritten by Nationwide Mutual Insurance Company, Columbus, Ohio; In WA coverage is underwritten by Nationwide Life Insurance Company, Columbus, Ohio and Nationwide Mutual Insurance Company, Columbus, Ohio

**EXPENSES CLAIMED: cont'd from Pg 2 (if necessary)**

Please provide supporting documentation of the expenses you are claiming in addition to this claim form

| Name of Provider | Date Incurred | Amount of Bill | Amount Paid by Other Insurance | Amount Claimed |
|---|---|---|---|---|
| | | | **TOTAL from table on Pg 2 =** | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |

**TOTAL AMOUNT CLAIMED $_____**

**MAILING INSTRUCTIONS:**

Send this form and any accompanying documentation to:

**Attn: Travel Insurance Claims**
**on behalf of Nationwide Mutual Insurance Company and affiliated companies**
P.O. Box 26222
Tampa, FL 33623
Or
E-mail your information to: NWTravClaims@cbpinsure.com
FAX: 800-560-6340

**Authorization For Release of Medical Information – To be Completed by Patient**

In order to process a claim for benefits, I AUTHORIZE any physician, hospital, or other Medical Provider to release to the Travel Insurance Claims Administrator, or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed two and one-half years from the date signed. I understand I have a right to receive a copy of this authorization.

**Date:** _____ **Signature:** _____

(Signature of Person Suffering Illness or Injury or legally authorized representative)

## State Fraud Notices

**(Alabama)** Any person who knowingly presents a false or fraudulent claim for payment of 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.

**(Alaska)** 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.

**(Arizona)** Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**(Arkansas)** 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.

**(California – Claim & Application Forms)** For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**(Colorado)** 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.

**(Delaware)** 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.

**(District of Columbia)** 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.

**(Florida)** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**(Idaho)** 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.

**(Indiana)** 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.

**(Kentucky) Application** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

**(Kentucky) Claim** 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.

(**Louisiana**) 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.

**(Maine)** 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.

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

**(Minnesota)** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**(New Hampshire)** 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.

**(New Jersey) Claim** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**(New Jersey) Application** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**(New Mexico)** 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.

**(New York)** 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 $5,000 and the stated value of the claim for each such violation.

**(Ohio)** 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.

**(Oklahoma)** 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.

**(Pennsylvania)** 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.

**(Rhode Island)** 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.

**(Tennessee)** 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.

**(Texas)** 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.

**(Virginia)** 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.

**(Washington)** 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.

**(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.

**(All Other States)** 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/or civil penalties.