Aspire Travel Claim Form

To help us process your claim quickly, please follow these guidelines:

1. Complete a separate claim form for each claim and for each insured person.
2. If you are submitting a claim following an accident or injury, please complete in full Sections A, B & D.
3. If you are submitting a Personal Accident claim, please complete Sections A, C & D.
4. Please email this fully completed form to the GBG's Claims Department with ALL original bills relating to the claim.

All submissions MUST be received by GBG within 60 DAYS of the date of the loss or commencement of treatment. Failure to provide required documents may delay or void the payment of your claim.

A. INSURED INFORMATION	
Name (Last, First, MI):	Policy Number:
Address:	
Postal/Zip Code:	Country:
E-mail:	Phone:
A $50 Claim deductible applies to each benefit. Policy Currency: ☒ US$	
CLAIMANT DETAILS (if different from above, such as Host Family etc.)	
Name (Last, First, MI):	
Address:	
Postal/Zip Code:	Country:
E-mail:	Phone:
Is the claim the result of an accident? ☐ Yes ☐ No	
PLEASE LIST DOCUMENTS ATTACHED:	

Sections B and/or C of this form should be completed by the Insured Person or (in the case of a minor) the parent or guardian. Please submit all medical invoices and receipts which are relevant to your claim. A delay in submitting this documentation could result in a delay in the settlement of your claim.

B. MEDICAL EXPENSES & HOSPITAL BENEFIT

Nature of illness/injury:

Date and time of illness/injury:

Please confirm where the illness/injury took place:

Please provide a detailed description of how the injury occurred:

Name and address of doctor(s) and/or hospital(s) from which treatment was received:

Details of insureds personal family physician / doctor:

Address:	Phone Number:
	Fax Number:
	Email:

If treatment was given in hospital as an inpatient, please provide the dates:

Was the Emergency Assistance Company contacted: ☐ Yes ☐ No If no, please state the reason why not:

If the Insured Person has suffered illness, has he/she suffered from this before? ☐ Yes ☐ No If yes, please provide details:

Does the Insured Person have Private Medical Insurance? ☐ Yes ☐ No If yes, provide the insurance carrier name, address and policy number:

FOR EU CITIZENS ONLY

Was an EHIC (European Health Insurance Card) taken on the trip? ☐ Yes ☐ No

Was this presented to the hospital/doctor? ☐ Yes ☐ No If no, please explain:

C. ACCIDENTAL DEATH & DISMEMBERMENT

In the event of a fatality, a Death Certificate issued by a licensed authority must be obtained, with the original copy being submitted to GBG.

When did the injury or (in the event of a fatality) death occur?

Please detail the nature of the loss or how the death occurred:

Was the injury or cause of death as a result of natural causes? ☐ Yes ☐ No

D. REIMBURSEMENT METHOD

Please reimburse: ☐ Primary Insured ☐ Provider (Payment by check)

REIMBURSEMENT METHOD: Request preferred method of reimbursement below.

☐ Check to Primary Insured's Address, as listed in PRIMARY INSURED INFORMATION section.

☐ Check to other Mailing Address:

☐ Send by Electronic Direct Deposit (U.S. banks only) or Wire Transfer (non-U.S. banks)

Bank Name:

Name on Account:

Account #/IBAN:

Routing #/ABA # (for Electronic Direct Deposit):

SWIFT code (for Wire Transfer):

Bank Address (for Wire Transfer):

D. DECLARATION

For Data Protection Purposes I/We acknowledge that any personal data secured from me/us as a result of this claim will be held and processed for insurance administration and claims investigation. For this purpose, the information may also be passed to selected third parties and reinsurers.

I/We consent to your processing of sensitive data about me/us and other persons who may be insured under the contract.

I/We understand that all personal data I/We supply must be accurate and I/We have the specific consent of those other persons insured to disclose their personal data.

I/We consent to the inquiry of information from other insurers, Credit and other information Agencies to check the answers we have provided and will authorize the release of such information.

I/We declare that on settlement I/We transfer all rights of subrogation and recovery to the Insurer and or/their Loss Adjuster. Please note that we have rights to salvage and we will exercise these rights where applicable.

I/We declare that, to the best of our knowledge, the information submitted in this form is correct and complete.

Insured Person	Parent or Duly Appointed Legal Guardian
Name:	Name:
Signature: By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual, handwritten signature.	Signature: By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual, handwritten signature.
Date:	Date:

Please email completed claim form and supporting documents to GBG's Claims Department at eclaims@gbg.com.

Claims Inquiries:

- **Email:** eclaims@gbg.com
- **Call U.S. Toll Free:** +1.877.916.7920
- **Call Outside of U.S.**: +1.949.916.7941