Event Ticket Cancellation Medical Claim Form

Insurance coverage is underwritten by StarNet Insurance Company,(domiciled in Iowa - California Certificate of Authority #6978) 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690.

Please complete in full and sign this claim form for reimbursement as part of your proof of loss.

SECTION A – CONTACT INFORMATION

Name of Insured _____ Date of Birth _____ MM/DD/YY

Day Telephone _____ Night Telephone _____

Home Address _____ City _____

State _____ Zip Code _____ Email Address _____

Mailing Address _____ City _____

State _____ Zip Code _____ Preferred Method of Contact: ☐ Mail ☐ Email ☐ Day Phone ☐ Night Phone

SECTION B – PLAN INFORMATION

Policy Number _____ Effective Date of Policy _____

Destination/Location of Event _____

Ticket Dates: Start Date _____ MM/DD/YY End Date (if multi-day event) _____ MM/DD/YY

Ticket Payment Date (earliest) _____ MM/DD/YY

Ticketing Vendor & Event Name _____

Vendor Order Confirmation Number _____

Reason for Cancellation _____

SECTION C – CLAIMED EXPENSES

Category	Amount	Required Support Documents
Event Ticket Cost	$	Copy of the order confirmation email
Less Refunds	$	Note: SecureTicket™ premium is nonrefundable
Total Claimed	$	Note: Cannot exceed the lesser of $5,000 per ticket or the insured per ticket cost.

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SECTION D – ILLNESS / ACCIDENT SATEMENT – TO BE COMPLETED BY PATIENT

Name of Person Having Sickness or Injury _____

Date of Birth _____ (MM/DD/YY) Relationship to Policyholder _____

Date Sickness or Injury Began _____ (MM/DD/YY) Date Ended _____ (MM/DD/YY)

Nature of Sickness or Injury (if injury, describe accident, including date and place) _____

_____

Period of Hospitalization – From _____ (MM/DD/YY) To _____ (MM/DD/YY)

Authorization for Release of Medical Information

In order to process a claim for benefits, I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as to diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any kind, and all such information is to be given to Berkley Group Companies: Berkley Life and Health Insurance Company, StarNet Insurance Company, or its authorized Administrators or their legal representatives. 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 (applicable to CA, CT, GA, HI, MA, MN, NC, NJ, OH and VA). For WI, this authorization shall be considered valid for the duration of the claim or policy term, whichever is longer. For all other states, this authorization is valid for 24 months from the date signed. I understand I, or my authorized representative, have a right to receive a copy of this authorization.

Signature _____ Date _____ (MM/DD/YY)

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SECTION E – PHYSICIAN'S SATEMENT – TO BE COMPLETED BY PHYSICIAN

If treatment received outside the United States, please send medical report in place of this form.

Name of Doctor _____ Address _____

Office Phone Number _____Fax Number _____

Name of Patient _____ Date of Birth _____
MM/DD/YY

Date symptoms first appeared or accident occurred _____ Date First Treated _____
MM/DD/YY MM/DD/YY

Was patient treated by someone else? ☐ Yes ☐ No If so, by whom? _____

When? _____
MM/DD/YY

If the patient is the Ticketholder, was the patient advised not to attend the event for which they are making a claim? ☐ Yes ☐ No

Was the patient's condition life-threatening? ☐ Yes ☐ No Did the patient require hospitalization? ☐ Yes ☐ No

If so, Period of Hospitalization: From _____ To _____
MM/DD/YY MM/DD/YY

Name and Address of Hospital _____

Has the patient received medication or other treatment for this condition, or for a related condition, by you or any other Physician during the 90 day period immediately prior to the Effective Date of the Policy noted above in Section B? ☐ Yes ☐ No

If so, please provide exact dates (MM/DD/YY) and provide details _____

Important Notice: 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.

For residents of 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 five thousand dollars and the stated value of the claim for each such violation.

(Fraud language varies by state, for additional state specific fraud warning language, please see below)

Physician Signature _____ Date Completed _____
REQUIRED MM/DD/YY

Please provide authentication of physician signature – physician stamp, physician credentialing information, letterhead of practice or other form of authentication

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SECTION F – REQUIRED INFORMATION*(1)

- ☐ Completed Claim Form, including completed Physician Statement section*(2) (signed and dated)
- ☐ Copy of Itemized Invoice/Ticket Order Confirmation showing amount paid for event tickets
- ☐ Penalty Letter from the Event Provider or Penalty Terms (if applicable)

*(1) We reserve the right to request additional information/ documentation as needed to process the claim.
*(2)The Physician Statement is mandatory. Failure to provide this information may result in a processing delay or closed/denial.

SECTION G – IMPORTANT NOTICE AND AUTHORIZATION

Important Notice: 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.

For residents of 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 five thousand dollars and the stated value of the claim for each such violation.

(Fraud language varies by state, for additional state specific fraud warning language, please see below)

By signing this claim form, I certify that all information given above is true and complete to the best of my knowledge.

Signature _____ Date Signed_____
REQUIRED MM/DD/YY

Print Name _____

Notice to CALIFORNIA RESIDENTS:

Please refer to the attached Notice of Personal Information Collected pursuant to California Consumer Privacy Act (CCPA)

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IMPORTANT NOTICE

For residents of 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.

For residents of Arizona: 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.

For residents of California: For your protection California law requires the following to appear on this form, 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.

For residents of 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.

For residents of Delaware and Idaho: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

For residents of Florida: 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.

For residents of Indiana: 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.

For residents of Kansas: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

For residents of Kentucky: 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.

For residents of Maryland: 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.

For residents of Maine, Tennessee, Virginia and 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 may include imprisonment, fines or a denial of insurance benefits.

For residents of Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For residents of 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.

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(Revised 2.14.20)

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

For residents of 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.

For residents of Ohio and Oklahoma: 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.

For residents of Oregon: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of 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.

For residents of Vermont: Any person who knowingly presents a false statement in a claim for proceeds of an insurance policy may be guilty of a criminal offense and subject to penalties under state law.

(Revised 2.14.20)

CLAIM SUBMISSION

Please return your scanned, completed and signed claim form and all required documents to:
iambuddy@us.crawco.com.

Or, mail the completed and signed claim form and all required documents to:

Crawford & Company
1605 N. Cedar Crest Blvd, Suite 407
Allentown, PA 18104

If you choose to mail your documents, please send a copy of your documents and retain the originals for your records. Crawford is unable to return any submitted documents. Upon receipt your claim will be thoroughly reviewed. It may be necessary for Crawford to request additional information before a final determination is made.

Should you require any assistance in completing this form, please do not hesitate to contact Crawford at 1-866-641-7922.

Should you have any questions concerning your submitted claim, please do not hesitate to contact Crawford at:

New Losses (Crawford ClaimsAlert 24/7): 1-877-346-0300 **Inquiries (Business Hours 8:30am-5pm EST):** 1-866-641-7922

W. R. Berkley Corporation
Notice of Personal Information Collected
(Pursuant to the California Consumer Privacy Act (CCPA))

This notice applies only to information received and collected by W. R. Berkley Corporation ("Berkley") from residents of the state of California.

In this notice, when we refer to "we", "us" or "our", it means one or more operating units of W. R. Berkley Corporation ("Berkley operating units").

When we refer to "you" and "your" in this notice, we mean a resident of the state of California whose personal information we may collect. More information about W. R. Berkley Corporation operating unit subsidiaries can be found on https://www.berkley.com/our-business/operating-units.

Below is a table showing the categories of personal information that one or more of the Berkley operating units collect in the course of performing insurance services and how it is used, Not every Berkley operating unit collects every category of personal information or uses it in all the ways listed below.

Personal Information Category	How it is Used
Identifiers (such as name, address, social security #, driver's license #, etc.) **Other Sensitive Information under California Law** *(Examples: physical description, financial information, medical information, etc.)* **Characteristics of protected classifications under California or federal law** *(Examples: race, sex, color, religion, national origin, marital status, etc.)* **Biometric information** *(Examples: fingerprints, keystroke patterns, gait patterns, sleep/health data, etc.)* **Geolocation Data** *(Information to identify physical location)* **Audio, electronic, visual, thermal, olfactory, or similar information.** *(Examples: audio and video recordings)* **Professional or employment-related information.** *(Example: job history)* **Education information** (information not publicly available as defined under federal law)	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.

Commercial information *(Examples: records of personal property, products, and services purchased or obtained, etc.)*	To perform insurance services for policyholders/ beneficiaries/claimants; security; prevent fraud and improper use; internal research; collections; comply with laws and regulations.
Internet or other electronic network activity information *(Examples: browsing/search history, visitor's interaction with a website, etc.)*	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.
Inferences drawn from any of the other categories of information. (use of any of the above categories to create a profile about a consumer)	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.

NEED MORE INFORMATION?

For additional information about how we collect, use, and share personal information, about California consumers' rights under the CCPA, and to make a consumer request, please see our online Privacy Policy at: https://www.berkley.com/privacy

This notice was updated on December 30, 2019