HCC Medical Insurance Services
251 N. Illinois Street, Suite 600
Indianapolis, Indiana 46204
main 317 262 2132 web www.hccmis.com

CLAIMANT'S STATEMENT

Lost Checked Luggage

PART A: Complete for all claims. **All Checks and Correspondence Will Be Sent To The Address Below**		
Claimant (Insured) Name:		
Sex:	Birthdate:	
Home Telephone:		Mailing Address (include Street Address, City, State, Country, and Postal Code):
Work Telephone:		
Fax Number:		
E-mail address:		
Plan Number:		Certificate Number:

Citizenship of Claimant: ________________ Home Country of Claimant: ________________
(Country where you principally reside & receive regular mail)

Country Visited: ____________________
(HCCMIS may request a copy of your passport)

Signature of Insured:	
Print Name:	Date:

DIRECTIONS:

1. Please complete all parts of this form.
2. Attach a copy of claim filed with airline carrier and a copy of their settlement.
3. **Mail to: HCC Medical Insurance Services**
   Box No. 2005
   Farmington Hills, MI 48333-2005
4. If you have any questions, please call 1-800-605-2282. If calling from outside the US, call collect to (317)262-2132.

INDIANA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: 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.