Rental Car Damage Claim Form

Please print legibly and complete ALL SECTIONS before submitting.
Email: iTravelClaims@imglobal.com
Additional submission options below.

To report a loss, submit this completed claim form along with required documentation.
Claims must be submitted within 90 days of the date of loss.
Benefits are paid on a reimbursement basis only.
Incomplete forms or missing documentation may delay processing.

Form to be completed by Renter or authorized representative. Note a completed alternate payee form is required to reimburse parties other than the insured policy holder.

REQUIRED DOCUMENTATION

- ☐ Booking Confirmation
  A copy of the original rental agreement and booking confirmation reflecting the reservation number, date, and time(s) of the rental
- ☐ Rental Company Damage Report / Initial Inspection Form / Return Inspection Form / Pre-agreement Walkthrough Form (if available)
- ☐ Itemized repair invoice from the rental company or at least 2 itemized repair estimates for approval
- ☐ Proof of Payment for Repairs (e.g., bank or credit card statement)
- ☐ Photos of Damage *(Including VIN Number, where possible)*
- ☐ Police Report *(if applicable)*
- ☐ Correspondence with rental company or third parties

INSURED INFORMATION

Insured's Name: *(Last, First, Middle)*	Policy Number:
Date of Birth: ___/___/___ *(MM/DD/YYYY)*	Complete Address:
Email Address:	
Cell Phone Number: *(with area code)*	
Are you listed on the rental agreement? ☐ Yes ☐ No	Drivers License Number:

Please note: If a third party is requesting payment, an alternate payee form completed by the named insured will be needed. By providing an email address and cell phone number on this form, you agree to electronic communications (including emails and SMS) about any claims that you have submitted.

PART 1. RENTAL VEHICLE INFORMATION

Rental Company:	Vehicle Make/Model:
VIN Number:	License Plate Number:
Rental Period Start Date: ___/___/___ *(MM/DD/YYYY)*	Rental Period End Date: ___/___/___ *(MM/DD/YYYY)*
Reservation Number:	Pick-up Location:
Drop-off Location:	
Purpose of Vehicle Rental:	
Name of Driver:	Date of Birth of Driver: ___/___/___ *(MM/DD/YYYY)*

PART 2. INCIDENT DETAILS

Date of Incident: ___/___/___ *(MM/ DD/YYYY)*	Time: ___ : ___ ___
How did damage occur:	
Who was responsible for incident?	
Was a third party involved and/or were there witnesses? ☐ Yes ☐ No	
If yes, explain:	
Location:	
Police Report Filed: ☐ Yes ☐ No	Date Reported to Police: ___/___/___ *(MM/ DD/YYYY)*
Location of police station:	Police reference number:

PART 3. DAMAGE DETAILS / COSTS

Description:	
Amount:	Total Amount Claimed: ***must match invoice submitted***

PART 4. OTHER COVERAGE

Do you currently have any other insurance which may cover the same loss? ☐ Yes ☐ No
Please provide any other insurance details in case benefits are to be coordinated:

PART 5. PAYMENT INFORMATION

Payee / Beneficiary:	Bank Name:
Account Number:	
ACH Routing Number:	

REQUESTOR AUTHORIZATION

By signing below, I request for an accommodation from and for Company to execute the above funds transfer instruction up tot he amount of benefits owed in accordance with under the insurance contract for funds transfers set forth in this agreement. I understand and acknowledge Recipients may receive less due to fees charged by the Recipient's bank and taxes, and any cancellation must occur within 30 minutes of sending the request, unless the funds have already been picked up or deposited.

Authorized Signature: X _____	Date: ___/___/___ *(MM/ DD/YYYY)*

If using this form, please print legibly and complete ALL SECTIONS before submitting.
Email: iTravelClaims@imglobal.com
Web: www.imglobal.com/secure-message-center
Address: IMG iTravelinsured® Claims, P.O. Box 241853, Apple Valley, MN 55124 USA,
Call: 1.317.655.9798
www.imglobal.com

CLAIM FORM FRAUD STATEMENT
FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

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.

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: 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.

CALIFORNIA: 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.

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.

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: 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.

KANSAS: A "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

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.

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 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.

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

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 there to commits a fraudulent insurance act, which is a crime and subjects such person 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.

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: 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.

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.

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 benefit.

TEXAS: Any person who knowingly presents a false or fraudulent claim for 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.

AUTHORIZATION

The undersigned authorizes Crum & Forster, United States Fire Insurance Company or its representative, or any health plan, healthcare provider, healthcare professional, MIB, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency, employer, benefit plan, or any other organization or person that has provided care, advice, diagnosis, payment, treatment, or services to the insured or on the insured's behalf, has any records or knowledge of the insured's health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the insured, and any non-medical information about the insured, to disclose the insured's entire medical record, file, history, medications, and any other information concerning the insured and to give any and all such information to the insured's agent of record and authorized representatives of the insurer, IMG, and their affiliates, and subsidiaries.

This information will be used to evaluate claims for benefits. Individuals have the right to refuse to sign the authorization without negative consequences to treatment or plan enrollment, except IMG will not be able to administer claims, determine benefit eligibility, or issue payments. The authorization is valid for the term of the insurance contract or plan under which a claim has been submitted. The undersigned understands that the insured has the right to receive a copy of this authorization upon request and revoke the authorization at any time in a written communication to IMG. A copy of this shall be as valid as the original. The undersigned acknowledges and understands there is the potential for the information to be subject to redisclosure by the recipient and to no longer be protected by applicable privacy and confidentiality laws.

The undersigned represents and warrants information or documents provided to IMG by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees:

1) A delay in the processing of this claim may occur if unacceptable proof of loss or an incomplete claim form is submitted. Proof of loss must be submitted within 90 days of the date of loss. IMG reserves the right to obtain further information needed to determine eligibility for benefits and the proper payee.
2) Any insurance coverage or benefit is contingent upon any statement made to IMG as being complete and correct.
3) If it is determined by IMG that any information provided by the undersigned in relation to a claim was incorrect, misleading, or fraudulent, IMG reserves the right to recover any payments made as a result of such misinformation. This recovery may include, but is not limited to, reimbursement of claim amounts, associated costs, and legal fees incurred by IMG in investigating and pursuing the recovery.
4) By submitting a claim, the undersigned agrees to cooperate fully with IMG in any investigation related to the claim and to provide any necessary documentation and information requested by IMG to verify the accuracy of the claim. Failure to cooperate or provide the requested documentation may result in the denial of the claim or the initiation of recovery proceedings by IMG.
5) Benefits under any contract will be paid only if IMG decides the applicant is entitled to them.
6) By providing an email address and cell phone number on this claim, you agree to electronic communications (including emails and SMS) about any claims that you have submitted.

Insured Signature: X _____ Date: ___/___/___ *(MM/ DD/YYYY)*

FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim may be subject to fines or imprisonment.