CLAIMS STANDARDIZED DATA REQUEST
Travel Line of Business

Content: This file should be downloaded from company system(s) and contain one record for each claim transaction (i.e. paid/denied/pending/closed w/o payment) that the company processed within the scope of the examination. Do not include expense payments to vendors.

For any fields where there are multiple entries, please repeat field as necessary.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the handling of Ttravel insurance claims within the scope of the examination:
- Cross-reference with the in-force data file to ensure completeness of exam data submitted; and
- Cross-reference to state(s) licensing information to ensure proper adjuster licensure.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
GrpID	6	5	A		Group ID number
GrpName	11	64	A		Group name
PolPre	75	3	A		Policy prefix (**Blank if NONE**)
PolNo	78	20	A		Policy number
PolSuf	98	3	A		Policy suffix (**Blank if NONE**)
PolForm	101	10	A		Policy form number
PolTyp	111	25	A		Type of policy (i.e., life, medical, trip cancellation, evacuation, package, comprehensive, etc.) **Please provide a list to explain any codes used**
CovTyp	136	25	A		Type of coverage purchased (i.e., trip cancellation, baggage delay, rental car, etc.) **Please provide a list to explain any codes used** (Repeat field as necessary)
CovLmt	161	10	N		Limit of coverage associated with each coverage type identified above (Repeat field as necessary)
PXWaiv	171	1	A		Is there a pre-existing conditions waiver on the policy? (Y/N)

Field Name	Start	Length	Type	Decimals	Description
TSupp	172	64	A		Name of travel supplier (wholesaler, tour operator, cruise line, website, etc)
TAgency	236	64	A		Name of travel agency
InsFirst	301	15	A		First name of insured
InsMid	316	15	A		Middle name of insured
InsLast	331	20	A		Last name of insured
InsIDNo	351	10	A		~~Number assigned to individual insured by the company~~ Insured ID number, if different from policy number or certificate number
InsAddr	361	25	A		Insured street address
InsCity	386	20	A		Insured city
InsSt	406	2	A		Insured state
InsZip	408	5	A		Insured ZIP code
CertNo	413	10	A		Certificate number assigned to applicant or insured
CertFirst	423	15	A		Certificate holder first name
CertMid	438	15	A		Certificate holder middle name
CertLast	453	20	A		Certificate holder last name
CertAddr	473	100	A		Certificate holder street address
CertCity	573	20	A		Certificate holder city
CertSt	593	2	A		Certificate holder state
CertZip	595	5	A		Certificate holder ZIP code
CertPuDt	600	10	D		Purchase date of certificate [MM/DD/YYYY]
CertEpDt	610	10	D		Date certificate will expire [MM/DD/YYYY]
ClmNo	620	10	A		Claim number
ClmPre	630	3	A		Claim number prefix **(Blank if NONE)**
ClmSuf	633	3	A		Claim number suffix **(Blank if NONE)**
AmtSub	636	10	N	2	Amount of claim submitted

Field Name	Start	Length	Type	Decimals	Description
~~PmtCvg~~	~~378~~	~~15~~	~~A~~		~~Coverage under which claim was paid/denied (i.e., life, medical, trip cancellation, evacuation, car rental, etc.)~~
~~PdClmAmt~~	~~393~~	~~10~~	~~N~~		~~Total amount of claim paid~~
ICPdAmt	646	10	N	2	Amount paid under interruption or cancellation of trip or event coverage
BPEPdAmt	656	10	N	2	Amount paid under loss of baggage or personal effects coverage
ARVPdAmt	666	10	N	2	Amount paid under damages to accommodations or rental vehicles coverage
SADPdAmt	676	10	N	2	Amount paid under sickness, accident, disability or death coverages occurring during travel
EvcPdAmt	686	10	N	2	Amount paid under emergency evacuation coverage
RoRPdAmt	696	10	N	2	Amount paid under repatriation of remains coverage
OthPdAmt	706	10	N	2	Amount paid under any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel as approved by the insurance commissioner of the applicable state
ClmPdDt	716	10	D		Claim paid date [MM/DD/YYYY]
ChkNo	726	10	A		Claim payment check number(s)
ClmPay	736	50	A		Claim payee
CmtFirst	786	15	A		First name of claimant
CmtMid	801	15	A		Middle name of claimant
CmtLast	816	20	A		Last name of claimant
CmtAddr	836	25	A		Claimant street address
CmtCity	861	20	A		Claimant city
CmtSt	881	2	A		Claimant state
CmtZip	883	5	A		Claimant ZIP code
DedAmt	888	10	N	2	Amount of deductible (dollar amount or percentage amount) (repeat field for any deductibles per coverage)

Field Name	Start	Length	Type	Decimals	Description
OtrSvc	898	1	A		Did this policy include other services, such as assistance services, concierge, or non-insurance services? **(Y/N)**
EffDt	899	10	D		Policy effective date [MM/DD/YYYY]
MGU	909	64	A		Name of third-party administrator or managing general underwriter authorized to adjudicate claims
NPN	973	6	A		Adjuster NPN (National (adjuster) number)
LossDt	979	10	D		Date loss occurred [MM/DD/YYYY]
RcvdDt	989	10	D		First notice of loss [MM/DD/YYYY]
ClmAckDt	999	10	D		Date company or its producer acknowledged claim to claimant [MM/DD/YYYY]
DtInvs	1009	10	D		Date claim investigation was completed [MM/DD/YYYY]
NtcInvDt	1019	10	D		Date of written notice to insured/claimant regarding incomplete investigation [MM/DD/YYYY]
DtClsd	1029	10	D		Date claim was closed [MM/DD/YYYY]
RsnClsd	1039	25	A		Reason claim was closed. Please provide a separate list with a description of the codes, i.e. paid, closed-no response, denied, partially denied, withdrawn (by insured), etc.
AmtDen	1064	10	N	2	Amount of claim ineligible or denied
ClmDnyDt	1074	10	D		Date claim was denied (blank if not denied) [MM/DD/YYYY]
ClmDenRsn	1084	25	A		Reason for claim denial **Please provide a list to explain any codes used**
EndRec	1109	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record This must be in the same character position for every record in this table.