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CLAIM FORM – TRIP CANCELLATION INSURANCE

IMPORTANT – PLEASE READ

Before completing this form, please review the checklist below and select the boxes that apply to your situation:

☐ *Have you requested a refund or a credit from your service provider (wholesaler/tour operator, carrier, lodging etc.)?*

Have you included the following documents to your request?

- ☐ This claim form FULLY completed and signed
- ☐ Proof of cancellation issued by your travel service provider(s)
- ☐ Copies of all refunds, credits and reimbursements
- ☐ Detailed invoices from your travel service provider(s) including their cancellation policies
- ☐ Proof of payment for the trip (such as a credit card or banking statement)
- ☐ Airline tickets (if applicable)
- ☐ Direct payment form completed and signed (if applicable)

Policyholder Information

Insurance company	Contract, certificate or identification number	Group number (if group insurance)	File number (optional)

Last Name | Gender ☐ M ☐ F

First name | Date of birth (Year / Month / Day)

Email | Telephone 1 | Telephone 2

Mailing address (No / Street / Apt. / City / Province / Postal code)

Is the policyholder submitting a claim? ☐ Yes ☐ No

Other claimants (other than the policyholder)

Spouse last name	First name	Gender ☐ M ☐ F	Date of birth (Year / Month / Day)
Dependent last name	First name	Gender ☐ M ☐ F	Date of birth (Year / Month / Day)
Dependent last name	First name	Gender ☐ M ☐ F	Date of birth (Year / Month / Day)
Dependent last name	First name	Gender ☐ M ☐ F	Date of birth (Year / Month / Day)

Other Insurance

Please list below all your, your spouse's or your parent's (if you are a dependent) other travel insurance coverage.

Group Insurance: ***(via an employer, a pension plan or any other group benefit plan)***

Policyholder _____ Date of birth (Year / Month / Day) _____ Insurance Company _____

Policy number _____ Company phone number _____

Identification number _____

Travel Insurance with a Credit Card Company:

Cardholder _____ Date of birth (Year / Month / Day) _____ Financial institution _____

Card number _____

Other Travel Insurance: ***(ex. : purchased from the trip provider)***

Policyholder _____ Date of birth (Year / Month / Day) _____ Insurance Company _____

Policy number _____ Company phone number _____

Have you already initiated a claim? ☐ Yes ☐ No *If so, please indicate the file number:* _____

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CLAIM FORM – TRIP CANCELLATION INSURANCE

IMPORTANT – Required information to process your claim

Date the trip was purchased (Year / Month / Day)	Cost of trip $	Type of claim ☐ Trip cancellation ☐ Delayed or cancelled flight ☐ Trip interruption ☐ Delayed return ☐ Other, specify: _____
Date the trip was cancelled with the travel provider (Year / Month / Day)	Amount claimed $	
Original departure date (Year / **Month** / **Day**) Original return date (Year / Month / Day)	Planned destination (city and country): _____	
Please indicate why the trip was cancelled or interrupted *(if necessary, continue on a separate sheet)*: _____		Have you obtained a credit or refund from your service provider(s)? ☐ Yes ☐ No *If yes, please attach a copy of the service providers' answers and ensure the details of the refunds and credits received are listed in the table below.*

Expenses & Fees Claimed

Fee description	Trip provider (supplier, carrier, online purchase, etc.)	Amount paid (CAD)	Reimbursement and credits already received (CAD)	Claimed amount (CAD)
E.g.: Vacation package	ABC Airline	1,000 $	250 $	750 $
		$	$	$
		$	$	$
		$	$	$
		$	$	$
				0 $

Agreement, Authorization and Subrogation

1. I hereby certify that I have not received any compensation for this loss giving rise to this claim other than that declared in this form.

2. I certify that I have not in any way caused or attempted to cause, directly or indirectly, this loss. I have not concealed or misrepresented any circumstances or any relevant facts regarding this coverage and its purposes.

3. I hereby agree to assign to CanAssistance Inc. all benefits payable by third parties for losses covered under the policy. Furthermore, following the application for reimbursement from CanAssistance Inc., I authorize third parties to pay CanAssistance Inc., the benefits payable regarding these losses.

4. To assess my application for benefits, I authorize insurance companies, airline companies, travel agents and any other organization or person who have information about me or the loss leading to my claim, to convey that information to CanAssistance Inc. Further, I authorize CanAssistance Inc. to provide my information to the insurer of my travel policy and to its reinsurers, to internal and external auditors and to any professional or organization mandated by CanAssistance Inc. within the context of my claim.

5. I declare that the information and details given on this form and the information provided in the attached documents are complete and true, and I am aware that any false declaration shall nullify the insurance certificate or insurance policy and shall result in the denial of my application for benefits.

6. In consideration of the benefits to be paid as per my policy, I hereby assign and subrogate to my insurer, my rights and remedies against anyone and any person who may be responsible or liable for amounts, damage, loss and/or injuries suffered by me and/or one or more of my family members, covered under my contract, up to all the amounts that will be paid by my insurer and thus hereby subrogate my insurer in all my rights and remedies for the said amounts.

7. I agree to accept no settlement without the prior approval of my insurer, failing which all amounts paid by my insurer will be reimbursed to it without delay, and I agree and accept to reimburse my insurer any amount that I can receive from anyone and any person who may be responsible or liable for such amounts, damage, loss and/or injury or from any person liable for it, up to the amount paid by my insurer.

Signature of Policyholder or legal heir: _____ **Date:** _____

Signature of Spouse if they are claiming: _____ **Date:** _____

Signature of the dependant, if they are of legal age: _____ **Date:** _____

SEND THIS DULY COMPLETED FORM ALONG WITH ALL OTHER REQUIRED DOCUMENTS TO CANASSISTANCE

Online via our secure website: **canassistance.com/en/policyholder/depot** Send all scanned documents and keep originals. We reserve the right to request the original documents up to one year from the date of submission of your claim.	*By regular mail:* **CanAssistance, Travel Claims Department** **PO BOX 3888, Station B, Montreal, Quebec, H3B 3L7**

Attending Physician Declaration
Trip Cancellation

To be completed by the physician. Any professional fees charged are the insured's responsibility.

Contract, certificate or identification number

Patient Information

Last Name | First name | Gender ☐ M ☐ F | Date of birth (year / month / day)

Information Concerning the Accident or Illness

Diagnosis or nature of the injury or illness: _____

Date the accident happened or first symptoms of the illness appeared: (year / month / day)

Date of first consultation: (year / month / day)

Has this person ever suffered from this illness before? ☐ Yes ☐ No

If so, please specify the date: (year / month / day)

Was the patient hospitalized due to this condition? ☐ Yes ☐ No

If so, please specify the dates: (year / month / day) to (year / month / day)

List all visits and/or treatment dates for this condition from initial consultation to present:

(year / month / day) (year / month / day) (year / month / day) (year / month / day)

Is this condition the complication of an underlying condition? ☐ Yes ☐ No

If so, please specify: _____

Was this patient referred to you by another doctor? ☐ Yes ☐ No

Name and address of the referring doctor: _____

If so, specify the referral date: (year / month / day)

Medical Recommendation as to the Capacity of Travelling

Is this patient the person travelling? ☐ Yes ☐ No

If so, was this patient unable to travel due to this illness or injury? ☐ Yes ☐ No

Indicate the date on which you recommended the trip be cancelled: (year / month / day)

Dates recommended not to travel: (year / month / day) to (year / month / day)

Are there any other reasons why this patient should not travel? _____

Comments

_____

_____

Physician Identification and Signature

Physician name and address (please print): _____

_____

Specialty: _____ Telephone: _____

Date: (year / month / day) Physician signature: _____

Physician's stamp

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REQUEST FOR PAYMENT BY DIRECT DEPOSIT

IMPORTANT NOTICE

If your claim is deemed admissible, by default a cheque will be sent to the policyholder. If you prefer to receive the reimbursement in your chequing account through direct deposit, please complete this form and attach a voided cheque.

We recommend that you select direct deposit for a number of reasons:

- Avoid the many possible days that come with receiving cheques by mail.
- Access your funds immediately without any holds that may be required by your financial institution.

SEND THIS DULY COMPLETED FORM ALONG WITH ALL OTHER REQUIRED DOCUMENTS TO CANASSISTANCE

Online via our secure website:	*By regular mail:*
canassistance.com/en/policyholder/depot Send all scanned documents and keep originals. We reserve the right to request the original documents up to one year from the date of submission of your claim.	**CanAssistance, Travel Claims Department** **PO BOX 3888, Station B, Montreal, Quebec, H3B 3L7**

Policyholder identification

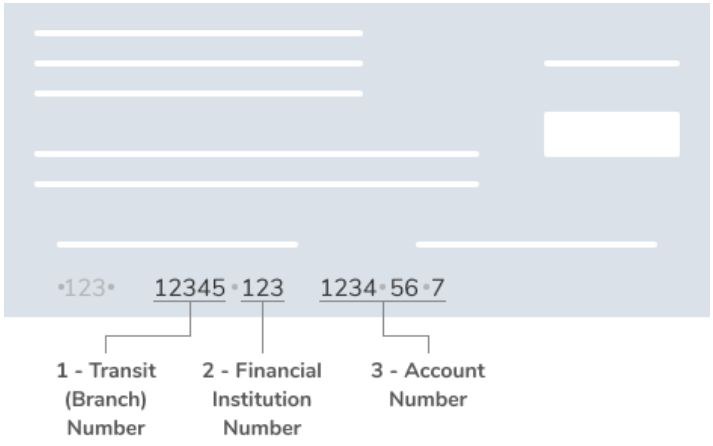
Name of the policyholder	Contract, certificate or identification number	File number

Bank Account Details (Canadian financial institutions only)

To avoid payment errors and delays, please attach a voided cheque. A copy can also been obtained through the online banking services of your financial institution.

Scan the document or take a photo of it, making sure all information is legible.

If you are unable to provide a voided cheque, please carefully complete the sections below.



Branch number _____

Institution number _____

Account number _____

I hereby request that my benefits be paid via electronic funds transfer (direct deposit) to the aforementioned account number.

Signature of the policyholder _____ Date _____