MANITOBA BLUE CROSS®

TRIP CANCELLATION CLAIM FORM

POLICY NUMBER	CLAIM	SURNAME	FIRST NAME	AGE

DATE POLICY PURCHASED	SCHEDULED DEPARTURE DATE	SCHEDULED RETURN DATE

Are any benefits provided under any other insurance plan? ☐ Yes ☐ No
If yes, complete the following:

Name of insurer _____

Policy or certificate number _____

Person insured _____

Date travel agency notified of cancellation, if trip cancelled prior to departure:

Date of member's return, if return prior to or after scheduled return date:

SECTION A: ONLY COMPLETE IF CANCELLATION IS DUE TO ILLNESS, INJURY OR DEATH

SELECT ONE : ☐ ILLNESS ☐ INJURY ☐ DEATH

1. Name of person ill/injured/deceased _____
2. Relationship of person to policyholder _____
3. ☐ Nature of illness or ☐ Nature of injury or ☐ Cause of death _____
4. Date of: ☐ first symptoms of illness or ☐ Date of injury or ☐ Date of death _____
5. If an injury, please give accident details (e.g. date, place):
6. Date of first treatment by physician: _____
7. Name of physician _____ Address of physician _____
8. If hospitalized: Date of admission: _____
   Date of discharge: _____
9. Name and address of hospital:

NOTE: YOU MUST SUBMIT A COMPLETED ATTENDING PHYSICIAN'S REPORT AND IF APPLICABLE A COPY OF THE DEATH CERTIFICATE

SECTION B: ONLY COMPLETE IF CANCELLATION IS DUE TO ONE OF THE FOLLOWING CAUSES

If cause of cancellation is due to any of the following, please check ✓ and include requested documents.

1. ☐ Damage to principal residence of you or your travel companion rendering it uninhabitable, due to fire, disaster or natural disaster or an unintentional act or unforeseeable event. A claim must be substantiated by a fire marshall or insurance report attesting to the fact that residence is uninhabitable.
2. ☐ A transfer by you or your travel companion's employer requiring you or your travel companion's permanent residence 160 km (100 miles) or more within 30 days of the scheduled departure or return date. A claim must be substantiated by a letter from the employer attesting to the transfer.
3. ☐ Involuntary loss of permanent employment provided that employment had been with the same employer for more than one year from the date of purchase. A claim must be substantiated by a letter from the employer.
4. ☐ Being summoned for jury duty. A claim must be substantiated by a documentation from applicable court.
5. ☐ Being summoned as a witness in a case being heard during the term of this agreement (excluding law enforcement officers). A claim must be substantiated by a copy of subpoena.
6. ☐ Quarantine of you or your travel companion. A claim must be substantiated by a copy of quarantine order from health authority.
7. ☐ Hijacking of you or your travel companion. A claim must be substantiated by a letter from transportation authority attesting to hijacking incident.
8. ☐ Missed connection due to a schedule change by a tour operator.
9. ☐ A travel advisory and/or travel warning by the Canadian Government to "Avoid all non-essential travel" or "Avoid all travel" advising Canadians not to travel to the country, region or city of your trip issued after the purchase date of the agreement.
10. ☐ Outbreaks of viral diseases that could put a pregnant person or unborn child at risk if the participant was unaware of the pregnancy at the time of booking.
11. ☐ You or your travel companion is delayed by weather conditions or natural disaster for at least 30% of your scheduled trip duration and you or your travel companion chose not to continue the trip. Applicable to Holiday Cancellation only.
12. ☐ A missed connection due to the delay of connecting carrier (airline, bus or train) resulting from weather conditions or mechanical failure; or delay of automobile (limousine, taxi, private automobile) resulting from a traffic accident, or from an emergency police-directed road closure (substantiated by a police report). This is subject to the connecting carrier or automobile being scheduled to arrive at the departure point not less than three hours prior to the time scheduled for flight departure or six hours prior to the time scheduled for sailing. Applicable to Holiday Cancellation only.

SECTION C: ONLY COMPLETE IF BAGGAGE IS LOST OR DELAYED (Applicable to Tour Package Only)

Explanation of delay or loss	Amount of claim
	Date of delay or loss
Location of delay or loss	Delay or loss reported to : ☐ Airline ☐ Cruise ☐ Train ☐ Bus line ☐ Police ☐ Hotel

Other insurance in force ☐ Yes ☐ No Supporting Documentation required/attached:

1. Copy of official report of loss (airline/train/boat/bus/police/hotel)
2. Proof of payment received from other insurer/travel supplier/other source.
3. Detailed receipts for essential clothing, toiletries purchased, verifying when these items were purchased.
4. CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF LOSS.

Name of other insurance company

Amount paid by other insurance company $

SECTION D: COMPLETE AS APPLICABLE

ATTACH APPLICABLE TICKETS AND RECEIPTS AND STATE AMOUNT OF CLAIM

		AMOUNT CLAIMED
1.	Pre departure airfare cancellation penalty	_____
2.	Extra return airfare due to delay or early return	_____
3.	Prepaid land arrangements cancellation penalty	_____
4.	Single supplement charge	_____
5.	Extra airfare costs due to missed connection	_____
6.	Prepaid land costs due to excessive delay	_____
7.	Extra transportation costs to rejoin tour	_____
	Total:	_____

I CERTIFY THAT I AM AWARE OF AND HAVE READ THE AUTHORIZATION AND CONSENT BELOW AND I AGREE THAT THIS CLAIM IS TRUE AND CORRECT AND AGREE THAT IT SHALL BE SUBJECT TO THE PROVISIONS OF THE CONTRACT. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL. I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE ENTIRE COST OF SERVICES RECEIVED.

			NAME AND ADDRESS OF POLICY HOLDER TO WHOM PAYMENT IS TO BE MADE.	
Date	RES. PHONE	BUS. PHONE	Name	
SIGNATURE OF MEMBER OR LEGAL REPRESENTATIVE			ADDRESS	
IF THERE IS CHARGE FOR COMPLETION OF FORMS IT IS THE RESPONSIBILITY OF THE INDIVIDUAL CLAIMING THE BENEFIT.			CITY/PROVINCE	POSTAL CODE

AUTHORIZATION & CONSENT

I understand that the personal information and personal health information provided herein as well as any other personal information and personal health information currently held or collected in the future by Manitoba Blue Cross and/or Blue Cross Life Insurance Company of Canada (collectively referred to as "Blue Cross") may be collected, used, or disclosed to administer the terms of the policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the company's business.

Depending on the type of coverage I carry, limited personal information or personal health information may be collected from and/or released to a third party. These include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the policy of which I am an eligible member. I understand that Blue Cross may retain service providers inside and outside of Canada to assist them in their business and further understand that my personal information may be subject to disclosure to law enforcement and other authorities, where required by law, both inside and outside of Canada, when such information is in the possession of Blue Cross or one of its authorized service providers.

I understand that I have provided my consent for Blue Cross to collect, use and disclose my personal information as outlined in the Manitoba Blue Cross Privacy Code. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information and personal health information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Manitoba Blue Cross's privacy policies or for questions as to the collection, use, or disclosure of my information, I may contact Manitoba Blue Cross at 204.775.0151 or 1.800.873.2583 or mb.bluecross.ca.

I authorize Blue Cross to collect, use and disclose my personal information and personal health information as described above.

A photostatic copy of this authorization shall be as valid as the original.

HOW TO SUBMIT YOUR CLAIM

Email: travel_claims@mb.bluecross.ca

Mail: PO Box 1046 Stn Main
Winnipeg MB R3C 2X7

In Person/ Drop Box: 599 Empress Street
Winnipeg, MB

Fax: 204.788.5591