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CLAIM FORM – TRIP CANCELLATION

CLAIM PROCESS

A. Complete both pages of the Claim Form;
B. Sign the Agreement and Authorization section;
C. If applicable, have the injured or sick person's physician complete and sign the Attending Physician Declaration;
D. Send all duly completed forms as well as any other required documents to CanAssistance.

By email:	By regular mail:
claims@canassistance.com Send all scanned documents and keep originals.	CanAssistance, Travel Claims Department 1981, McGill College Avenue, Suite 400, Montreal, Quebec H3A 2W9

INSURANCE COMPANY	GROUP NUMBER (Optional)
CONTRACT NUMBER	FILE NUMBER (Optional)

Policyholder

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		

Claimants (other than policyholder)

Spouse: Last name	Gender ☐ M ☐ F
First name	Date of birth Year / Month / Day
Dependent child: Last name	Gender ☐ M ☐ F
First name	Date of birth Year / Month / Day
Dependent child: Last name	Gender ☐ M ☐ F
First name	Date of birth Year / Month / Day
Dependent child: Last name	Gender ☐ M ☐ F
First name	Date of birth Year / Month / Day

Agreement and Authorization

1. 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.

2. I hereby authorize any licensed physician, practitioner, hospital or medical institution, insurance company, the Medical Information Bureau or any other agency, institution or person who has information or documents about me or a member of my family, or my state of health or that of a member of my family (including all previous medical information) to convey that information or forward those documents to CanAssistance Inc.

3. 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.

Signature of Policyholder or legal heir: _____ Date: _____

Signature of Spouse if he or she is claiming: _____ Date: _____

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FOR OFFICE USE

Trip Information

Date the trip was purchased (Year / Month / Day)

Cost of trip $

Date the trip was cancelled with the travel provider (Year / Month / Day)

Amount claimed $

Please indicate why the trip was cancelled or interrupted: _____

Type of claim

- ☐ Trip cancellation
- ☐ Delayed or cancelled flight
- ☐ Trip interruption
- ☐ Delayed return
- ☐ Other, specify _____ .

Other Insurance

Do you or does your spouse or child have another travel insurance? ☐ YES ☐ NO If so, please provide the following information.

Group Insurance:

Policyholder _____ Insurance Company _____

Policy number _____ Company phone number _____

Identification number _____

Tavel Insurance with a Credit Card Company:

Cardholder _____ Financial institution _____

Card number _____

Other Travel Insurance:

Policyholder _____ Insurance Company _____

Policy number _____ Company phone number _____

Have you already initiated a claim? ☐ YES ☐ NO If so, please indicate the file number: _____

If Claiming due to a Death

Name of the deceased

Relationship to the deceased

Cause of death

Date of death (Year / Month / Day)

Hospitalization period, if applicable (From Year / Month / Day to Year / Month / Day)

If Claiming due to an Illness or Injury

Name of the injured or sick person

Relationship to the injured or sick person

Date when first symptoms appeared or accident occured (Year / Month / Day)

Nature of the illness or accident

Complete name and address of physician consulted

Claim for Non-Refundable Fees and/or Additional Expenses

Fee description	Trip provider (supplier, carrier, online purchase, etc.)	Amount paid (CAD)	Reimbursement already received (CAD)	Claimed amount (CAD)
Ex.: Vacation Package	ABC Travel	$1,000	$250	$750
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$

Please use a seperate sheet if needed.

TOTAL (CAD) : $ 0