CanAssistance

# 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: claims@canassistance.com Send all scanned documents and keep originals. | By regular mail: CanAssistance, Travel Claims Department 550 Sherbrooke West, Suite B-9, Montréal, Québec, H3A 3S3 |
|---|---|

| 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 autorize 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: ____________

01QRV0013B-F (16-04)

CanAssistance

# CLAIM FORM – TRIP CANCELLATION

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) :** $