CLAIM – TRIP CANCELLATION BENEFIT

IMPORTANT NOTICE

This document is intended to help you complete the form to file a claim for a trip cancellation or interruption benefit. Please read it carefully as this information is essential for processing your claim.

An incomplete claim may cause additional delay in the processing of your file.

How to make a claim

ESSENTIAL DOCUMENTS TO SUBMIT WITH CLAIMS RELATED TO *THE COVID-19 PANDEMIC:*

- ☐ The "Claim Form – Cancellation Benefit" duly completed and signed;
- ☐ Original purchase invoice (travel agency, transport, Internet);
- ☐ Electronic ticket(s);
- ☐ Proof of payment (e.g.: credit card statement that shows the transaction, copy of the cashed cheque, etc.) – WARNING: An invoice is NOT a proof of payment;
- ☐ Cancellation confirmation as well as copies of all refund (credits *) received from other providers.

**Reminder: For most of our insurers, a credit is equivalent to a reimbursement. If you choose to refuse the credit, your claim may not be eligible for a partial (or full) refund. For more information, we invite you to consult your insurer's website.*

ESSENTIAL DOCUMENTS TO SUBMIT WITH CLAIMS RELATED TO *OTHER REASONS* (DEATH, ILLNESS OR OTHER)

- ☐ The "Claim Form – Cancellation Benefit" duly completed and signed;
- ☐ Letter detailing your version of the events that led to the claim;
- ☐ Based on the event that caused the claim:
  - o "Attending physician's declaration - Cancellation benefit" form duly completed and signed by the attending physician of the injured or ill person OR;
  - o Detailed medical report from the attending physician abroad that justifies the necessity to interrupt or extend the trip OR;
  - o Documentary evidence that confirms the reason for the trip cancellation/interruption or delayed return (e.g.: police report, death certificate, letter from the airline company, damage report. etc.
- ☐ Original purchase invoice (travel agency, transport, Internet);
- ☐ Electronic ticket(s);
- ☐ Proof of payment (e.g.: credit card statement that shows the transaction, copy of the cashed cheque, etc.) WARNING: An invoice is NOT a proof of payment;
- ☐ Cancellation confirmation as well as copies of all refund received from other providers.

ADDITIONAL DOCUMENTS TO PROVIDE IN CASE OF:

Trip interruption/ delayed return:

- ☐ New electronic ticket(s) as well as the invoice and proof of payment;
- ☐ Original receipts/invoices of additional fees incurred (if applicable).

Flight delay/ flight cancellation:

- ☐ Letter from the airline confirming the reason of the flight delay or cancellation;
- ☐ Original receipts/invoices of additional fees incurred (if applicable).

Additional Information

If you cannot provide all the requested documents, please provide us with an explanation in a letter attached to your claim. We reserve the right to request additional documents or information if needed. Your claim will be processed as soon as possible upon receipt of your documents. However, factors may influence claim processing times, such as submitting an incomplete file or if documents are missing. Admissible expenses are reimbursed in Canadian dollars, to the policy holder.

Should you have any questions about your claim, please contact us by using the phone number on your insurance card or by email at bluecross@canassistance.com.

We recommend you keep a copy of your claim for record-keeping purposes.

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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:
bluecross@canassistance.com Send all scanned documents and keep originals.	CanAssistance, Travel Claims Department PO Box 3888, Station B, Montreal, Quebec, H3B 3L7

INSURANCE COMPANY	POLICY NUMBER (Optional)
IDENTIFICATION NUMBER	FILE NUMBER (Optional)

Policyholder

Last name	Date of birth (Year / Month / Day)
First name	Telephone 1
Email	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	
First name	Date of birth (Year / Month / Day)
Dependent child: Last name	
First name	Date of birth (Year / Month / Day)
Dependent child: Last name	
First name	Date of birth (Year / Month / Day)
Dependent child: Last name	
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 comp lete 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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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) : $

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Attending Physician Declaration
Trip Cancellation

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

IDENTIFICATION NUMBER

Patient Information

Name | First name | 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 th 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

Name and address of the physician (Please print): _____

_____

Speciality: _____ Telephone: _____

Date: year / month / day

Signature of the physician: _____

Physician's stamp

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