MEDAVIE BLUE CROSS™

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 Medavie Blue Cross.

By Regular Mail:
Medavie Blue Cross
c/o Travel Plan Programs
644 Main St. PO Box 220
Moncton, NB E1C 8L3

By Fax:
506-867-4125

By Email:
travel.claims@medavie.bluecross.ca
Send all scanned documents and keep originals.

Inquiries Atlantic and Ontario Regions : 1-800-667-4511
Inquiries Quebec Region:1-888-588-1212

Attach the following documents (if applicable):

- A copy of your original itinerary showing the date of booking;
- If your original itinerary was modified, please also include a copy of your revised booking.
- Confirmation of the reason why you need to claim these benefits:
- If your flight was cancelled or delayed, we will need documentation from the airline showing the reason of cancellation or delay;
- Proof of payment for all expenses claimed.
- For each expense, please provide documentation showing either you have been refunded part of the cancelled expenses, or that these expenses are completely non-refundable.

POLICYHOLDER

Last Name: _____ First Name: _____

Gender: ☐ Male ☐ Female Date of Birth: _____ (Year / Month / Day) Provincial Health Plan Number: _____

Policy Number: _____ Identification Number: _____

Telephone Number (Home): _____ Telephone Number (Mobile): _____

Mailing Address (Nº, Street, Apt): _____

City: _____ Province: _____ Postal Code: _____

Email: _____ Is the policyholder submitting a claim? ☐ Yes ☐ No

CLAIMANTS (other than Policyholder)

Spouse: Gender: ☐ Male ☐ Female Date of Birth: _____ (Year / Month / Day) Provincial Health Plan Number: _____

Last Name: _____ First Name: _____

Dependent Child: Gender: ☐ Male ☐ Female Date of Birth: _____ (Year / Month / Day) Provincial Health Plan Number: _____

Last Name: _____ First Name: _____

Dependent Child: Gender: ☐ Male ☐ Female Date of Birth: _____ (Year / Month / Day) Provincial Health Plan Number: _____

Last Name: _____ First Name: _____

Dependent Child: Gender: ☐ Male ☐ Female Date of Birth: _____ (Year / Month / Day) Provincial Health Plan Number: _____

Last Name: _____ First Name: _____

AGREEMENT AND AUTHORIZATION

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, the member of any policy under which I am a participant and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

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

This consent complies with federal and provincial privacy laws. For additional information regading privacy policies at Medavie Blue Cross, visit medaviebc.ca.

Signature of Policyholder or legal heir: _____ Date: _____ (Year / Month / Day)

Signature of Spouse if he or she is claiming: _____ Date: _____ (Year / Month / Day)

FORM-985E 11/18

MEDAVIE BLUE CROSS™

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: _____

Company Telephone Number: _____ Policy Number: _____ ID Number: _____

Travel Insurance with a Credit Card Company:

Cardholder: _____ Financial Institution: _____

Card Number: _____

Other Travel Insurance:

Policyholder: _____ Insurance Company: _____

Company Telephone Number: _____ Policy Number: _____ ID 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 injured or sick person: _____ 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 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
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
			TOTAL (CAD):	$

Please use a separate sheet if needed.

FORM-985E 03/18