

**CLAIMS PROCESS**

- A. Complete both pages of the « Claim Form – Baggage Benefit »;
- B. Sign the « Agreement and Authorization » section;
- C. Compile a list of stolen or damaged items or, in case of delayed baggage, a list of necessary toiletries and clothing;
- D. Send all duly completed forms as well as any other required documents to CanAssistance.

Online via our secure website:  
[canassistance.com/en/policyholder/depot](http://canassistance.com/en/policyholder/depot)  
 Send all scanned documents and keep originals. We reserve the right to request the original documents up to one year from the date of submission of your claim.

By regular mail:  
**CanAssistance, Travel Claims Department**  
**PO BOX 3888, Station B, Montreal, Quebec, H3B 3L7**

CONTRACT NUMBER	FILE NUMBER (Optional)
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**Policyholder Information**

Last name		Gender <input type="checkbox"/> M <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			

**Claimants (other than policyholder)**

Spouse last name	First name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth Year                      Month                      Day
Dependant child last name	First name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth Year                      Month                      Day
Dependant child last name	First name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth Year                      Month                      Day
Dependant child last name	First name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth Year                      Month                      Day

**Agreement and Authorization**

1. I hereby certify that I have not received any compensation for this loss giving rise to this claim other than that declared in this form.

2. I certify that I have not in any way caused or attempted to cause, directly or indirectly, this loss. I have not concealed or misrepresented any circumstances or any relevant facts regarding this coverage and its purposes.

3. 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.

4. To assess my application for benefits, I authorize insurance companies, airline companies, travel agents and any other organization or person who have information about me or the loss leading to my claim, to convey that information to CanAssistance inc. Further, I authorize CanAssistance inc. to provide my information to the insurer of my travel policy and to its reinsurers, to internal and external auditors and to any professional or organization mandated by CanAssistance inc. within the context of my claim.

5. 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 and shall result in the denial of my application for benefits.

Signature of Policyholder or legal heir: \_\_\_\_\_ Date : \_\_\_\_\_

Signature of Spouse if he or she is claiming: \_\_\_\_\_ Date : \_\_\_\_\_

01CAN0118A (2022-07)

FOR OFFICE USE

**Information about the incident**

Type of claim  Damage  Delay  Loss  Theft

Place of incident (city and country)

Date of incident

Year | Month | Day

Destination

Airline

Date of departure

Year | Month | Day

Date of return

Year | Month | Day

Number of checked baggage

Number of lost or delayed baggage

Number of hours delayed

Date baggage was received

Year | Month | Day

Did you report the incident to the police, the airline company or any other authority?  Yes  No

**Other Insurance**

Do you, 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 \_\_\_\_\_

**Travel 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: \_\_\_\_\_

**Essential Documents to Submit**

**For all claims:**

- The « Claim Form – Baggage Benefit » duly completed and signed;
- Detailed list of stolen or damaged items or, in case of delayed baggage, a list of necessary toiletries and clothing;
- A letter detailing your version of events and circumstances leading to the claim;
- Detailed invoice(s) of your travel arrangements (travel agency or e-agency);
- Electronic airline tickets and labels confirming baggage check;
- If baggage is covered by a credit card insurance, account statement(s) proving the entire costs of transportation (and if applicable, accommodation expenses) have been paid with the credit card;
- **According to the event giving rise to the claim:**
  - Police or other competent authority's report regarding the theft;
  - Airline company's report regarding the theft, loss, damage or delay of baggage;
  - Purchase receipts for stolen or damaged items or purchase receipts for necessary toiletries and clothing in case of delayed baggage;
  - Irregularity Report issued by the air carrier;
  - Letter of settlement (payment) or denial of the airline company.

An incomplete claim may cause additional delays in processing your file. If you can't submit all requested documents, please provide us with an explanation in a letter attached to your claim. We reserve the right to request original documents or additional information if needed. Please keep a copy of your supporting documents for your records.

Should you have any questions about your claim, please contact our customer service toll-free at 1-855-445-5173 or 1-825-509-7675 Monday through Friday from 8:30 am to 8:00 pm (EST) or by email at [bluecross@canassistance.com](mailto:bluecross@canassistance.com).

Disclaimer: Email is not a secure method of communication and should only be used for the transmission of non-confidential information.



**IMPORTANT NOTICE**

If your claim is deemed admissible, by default a cheque will be sent to the policyholder. If you prefer to receive the reimbursement in your chequing account through the direct deposit option, please complete this form and attach a sample cheque.

We recommend that you select direct deposit for a number of reasons:

- Avoid the many possible days that come with receiving cheques by mail.
- Access your funds immediately without any holds that may be required by your financial institution.

Online via our secure website:

[canassistance.com/en/policyholder/depot](http://canassistance.com/en/policyholder/depot)

Send all scanned documents and keep originals. We reserve the right to request the original documents up to one year from the date of submission of your claim.

By regular mail :

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**Policyholder identification**

Name of the policyholder

Contract or certificate number

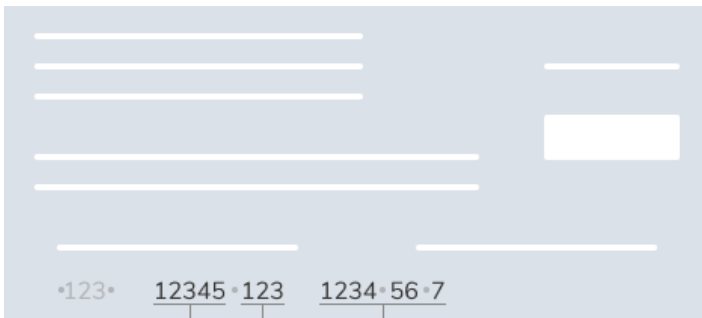
File number

**Bank Account Details (Canadian financial institutions only)**

To avoid payment errors and delays, please attach a sample cheque. A copy can also be obtained through the online banking services of your financial institution.

Scan the document or take a photo of it, making sure all information is legible.

If you are unable to provide a sample check, please carefully complete the sections below.



Branch number \_\_\_\_\_

Institution number \_\_\_\_\_

Account number \_\_\_\_\_

1 - Transit (Branch) Number  
2 - Financial Institution Number  
3 - Account Number

I hereby request that my benefits be paid via electronic funds transfer (direct deposit) into the aforementioned account number.

Signature of the policyholder \_\_\_\_\_

Date day / month / year