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# 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:
  - "Attending physician's declaration - Cancellation benefit" form duly completed and signed by the attending physician of the injured or ill person OR;
  - Detailed medical report from the attending physician abroad that justifies the necessity to interrupt or extend the trip OR;
  - 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 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.

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

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

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# CLAIM FORM – TRIP CANCELLATION INSURANCE

## IMPORTANT – PLEASE READ

**Before completing this form, please review the checklist below and select the boxes that apply to your situation:**

☐ *Have you requested a refund or a credit from your service provider (wholesaler, carrier, lodging etc.)*

*Have you included the following documents to your request?*

- ☐ This claim form FULLY completed and signed
- ☐ Proof of cancellation issued by your travel service provider(s)
- ☐ Copies of all refunds, credits and reimbursements
- ☐ Detailed invoices from your travel service provider(s) including their cancellation policies
- ☐ Proof of payment for the trip (such as a credit card or banking statement)
- ☐ Airline tickets (if applicable)
- ☐ Direct payment form completed and signed (if applicable)

## Policyholder Information

| Insurance company | Contract number | File number (optional) |
|---|---|---|
| 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 | | |

## Other claimants (other than the policyholder)

| | | | |
|---|---|---|---|
| Spouse last name | First name | Gender ☐ M ☐ F | Date of birth Year / Month / Day |
| Dependant child last name | First name | Gender ☐ M ☐ F | Date of birth Year / Month / Day |
| Dependant child last name | First name | Gender ☐ M ☐ F | Date of birth Year / Month / Day |
| Dependant child last name | First name | Gender ☐ M ☐ F | Date of birth Year / Month / Day |

## 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:* _____

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# CLAIM FORM – TRIP CANCELLATION INSURANCE

## IMPORTANT – Required information to process your claim

| | | | |
|---|---|---|---|
| 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 | $ |
| Original departure date (Year / Month / Day) | | Planned destination (city and country): | |
| Original return date (Year / Month / Day) | | | |

Type of claim

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

Please indicate why the trip was cancelled or interrupted *(if necessary, continue on a separate sheet)*:

_____

_____

_____

_____

Have you obtained a credit or refund from your service provider(s)? ☐ Yes ☐ No

*If "yes", plese attach a copy of the service providers' answer and ensure the details of the refunds and credits received are listed in the table below.*

## Expenses & Fees Claimed

| Fee description | Trip provider (supplier, carrier, online purchase, etc.) | Amount paid (CAD) | Reimbursement and credits already received (CAD) | Claimed amount (CAD) |
|---|---|---|---|---|
| Ex. : Vacation package | ABC wholesaler | 1,000 $ | 250 $ | 750 $ |
| | | $ | $ | $ |
| | | $ | $ | $ |
| | | $ | $ | $ |
| | | $ | $ | $ |
| | | | | 0 $ |

## Agreement, Authorization and Subrogation

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.

6. In consideration of the benefits to be paid as per my policy, I hereby assign and subrogate to my insurer, my rights and remedies against anyone and any person who may be responsible or liable for amounts, damage, loss and/or injuries suffered by me and/or one or more of my family members, covered under my contract, up to all the amounts that will be paid by my insurer and thus hereby subrogate my insurer in all my rights and remedies for the said amounts.

7. I agree to accept no settlement without the prior approval of my insurer, failing which all amounts paid by my insurer will be reimbursed to it without delay, and I agree and accept to reimburse my insurer any amount that I can receive from anyone and any person who may be responsible or liable for such amounts, damage, loss and/or injury or from any person liable for it, up to the amount paid by my insurer.

**Signature of Policyholder or legal heir :** _____ **Date :** _____

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

**Signature of the dependant, if she or he is of legal age :** _____ **Date :** _____

## SEND THE DULY COMPLETED FORM ALONG WITH ALL OTHER REQUIRED DOCUMENTS TO CANASSISTANCE

*Online via our secure website:*
**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**

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# Attending Physician Declaration
# Trip Cancellation

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

Contract Number

## Patient Information

Name | First name | Gender ☐ M ☐ F | 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 the 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

If so, specify the referral date: (year / month / day)

Name and address of the referring doctor: _____

## 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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**REQUEST FOR PAYMENT BY DIRECT DEPOSIT**

## 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:*<br>**canassistance.com/en/policyholder/depot**<br>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 :*<br>**CanAssistance, Travel Claims Department**<br>**PO BOX 3888, Station B, Montreal, Quebec, H3B 3L7** |

## Policyholder identification

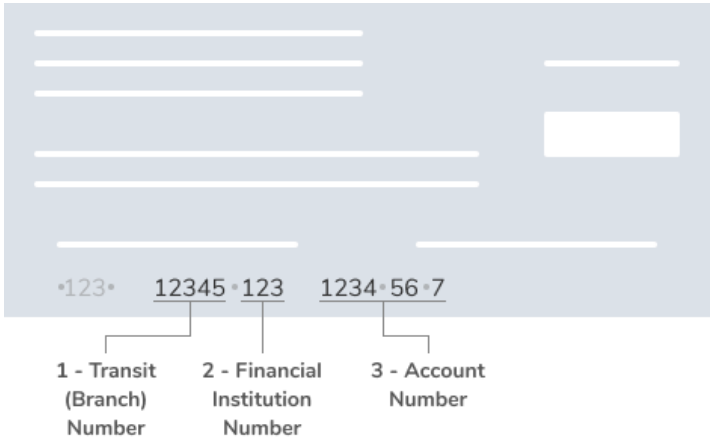
| Name of the policyholder | Contract or certificate number | File number |
|---|---|---|
| | | |

## Bank Account Details (Canadian financial institutions only)

**To avoid payment errors and delays, please attach a sample cheque. A copy can also been 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 _____

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 _____