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* IMPORTANT NOTICE – CANCELLATION BENEFIT*

This document is intended to help you complete the attached 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.

ESSENTIAL DOCUMENTS TO SUBMIT WITH ALL CLAIMS:

- 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.);
- 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).

If you can't 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.

Should you have any questions about your coverage or the claims process, please contact us at 514-286-8336 or at 1 800 264-1852, from Monday to Friday, 8:30am to 5:00pm (Eastern Time).

Please keep a copy of your supporting documents for your own personal files.

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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:
claims@canassistance.com Send all scanned documents and keep originals.	CanAssistance, Travel Claims Department 1981, McGill College Avenue, Suite 400, Montreal, Quebec H3A 2W9

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 / 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 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 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: _____

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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.

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

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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