



### **\* 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.

**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:  
[claims@canassistance.com](mailto:claims@canassistance.com)  
 Send all scanned documents and keep originals.

By regular mail:  
 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 <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		Gender <input type="checkbox"/> M <input type="checkbox"/> F	
First name		Date of birth Year                      Month                      Day	
Dependent child: Last name		Gender <input type="checkbox"/> M <input type="checkbox"/> F	
First name		Date of birth Year                      Month                      Day	
Dependent child: Last name		Gender <input type="checkbox"/> M <input type="checkbox"/> F	
First name		Date of birth Year                      Month                      Day	
Dependent child: Last name		Gender <input type="checkbox"/> M <input type="checkbox"/> 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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FOR OFFICE USE

**Trip Information**

Date the trip was purchased	Year	Month	Day	Cost of trip \$	Type of claim <input type="checkbox"/> Trip cancellation <input type="checkbox"/> Delayed or cancelled flight <input type="checkbox"/> Trip interruption <input type="checkbox"/> Delayed return <input type="checkbox"/> Other, specify _____
Date the trip was cancelled with the travel provider	Year	Month	Day	Amount claimed \$	
Please indicate why the trip was cancelled or interrupted:					

**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	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 occurred	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
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$
<b>TOTAL (CAD) :</b>				\$

Please use a separate sheet if needed.

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

Contract Number

### Patient Information

Name	First name	Gender	Date of birth
		<input type="checkbox"/> M <input type="checkbox"/> F	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: \_\_\_\_\_ to \_\_\_\_\_  
year month day 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: \_\_\_\_\_ to \_\_\_\_\_  
year month day 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): \_\_\_\_\_

Physician's stamp

Specialty: \_\_\_\_\_ Telephone: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of the physician: \_\_\_\_\_  
year month day