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 Can Assistance.

By email:
claims@canassistance.com
Send all scanned documents and keep originals.

By regular mail:
Can Assistance, Travel Claims Department
1981, McGill College Avenue, Suite 400, Montreal, Quebec H3A 2W9

CLAIM FORM – TRIP CANCELLATION

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  Province  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 Can Assistance Inc. all benefits payable by third parties for losses covered under the policy. Furthermore, following the application for reimbursement from Can Assistance Inc., I authorize third parties to pay Can Assistance 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 Can Assistance 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:  ______________
CLAIM FORM – TRIP CANCELLATION

Trip Information

Date the trip was purchased

Date the trip was cancelled with the travel provider

Cost of trip $______________

Amount claimed $______________

Type of claim

☐ Trip cancellation
☐ Delayed or cancelled flight
☐ Trip interruption
☐ Delayed return
☐ Other, specify _____________________________.

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 ________________________________

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: ________________________________

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 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

<table>
<thead>
<tr>
<th>Fee description</th>
<th>Trip provider (supplier, carrier, online purchase, etc.)</th>
<th>Amount paid (CAD)</th>
<th>Reimbursement already received (CAD)</th>
<th>Claimed amount (CAD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex.: Vacation Package</td>
<td>ABC Travel</td>
<td>$1,000</td>
<td>$250</td>
<td>$750</td>
</tr>
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</tbody>
</table>

Please use a separate sheet if needed.

TOTAL (CAD): $______________
To be completed by the physician. Any professional fees charged are the insured’s responsibility.

### Patient Information

<table>
<thead>
<tr>
<th>Name</th>
<th>First name</th>
<th>Gender</th>
<th>Date of birth</th>
</tr>
</thead>
</table>

### Information Concerning the Accident or Illness

<table>
<thead>
<tr>
<th>Diagnosis or nature of the injury or illness:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Date the accident happened or first symptoms of the illness appeared:</td>
<td></td>
</tr>
<tr>
<td>Date of first consultation:</td>
<td></td>
</tr>
<tr>
<td>Has this person ever suffered from this illness before?</td>
<td>Yes</td>
</tr>
<tr>
<td>If so, please specify the date:</td>
<td></td>
</tr>
<tr>
<td>Was the patient hospitalized due to this condition?</td>
<td>Yes</td>
</tr>
<tr>
<td>If so, please specify the dates:</td>
<td>to</td>
</tr>
<tr>
<td>List all visits and/or treatment dates for this condition from initial consultation to present:</td>
<td></td>
</tr>
<tr>
<td>Is this condition the complication of an underlying condition?</td>
<td>Yes</td>
</tr>
<tr>
<td>If so, please specify:</td>
<td></td>
</tr>
</tbody>
</table>

### Medical Recommendation as to the Capacity of Travelling

<table>
<thead>
<tr>
<th>Is this patient the person travelling?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If so, was this patient unable to travel due to this illness or injury?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Indicate the date on which you recommended the trip be cancelled:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dates recommended not to travel:</td>
<td>to</td>
<td></td>
</tr>
<tr>
<td>Are there any other reasons why this patient should not travel?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Comments


### Physician Identification and Signature

<table>
<thead>
<tr>
<th>Name and address of the physician (Please print):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Speciality:</td>
<td>Telephone:</td>
</tr>
<tr>
<td>Date:</td>
<td>Signature of the physician:</td>
</tr>
</tbody>
</table>

Can Assistance, Travel Claims Department: 1981, McGill College Avenue, Suite 400, Montreal, Quebec H3A 2W9 - Fax: 514-286-8409 or 1-800-210-0015