

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:
 - o “Attending physician’s declaration - Cancellation benefit” form duly completed and signed by the attending physician of the injured or ill person OR;
 - o Detailed medical report from the attending physician abroad that justifies the necessity to interrupt or extend the trip OR;
 - o 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 us by using the phone number on your insurance card or by email at bluecross@canassistance.com.

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

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:
bluecross@canassistance.com
 Send all scanned documents and keep originals.

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

INSURANCE COMPANY	POLICY NUMBER (Optional)
IDENTIFICATION NUMBER	FILE NUMBER (Optional)

Policyholder

Last name	Date of birth Year Month Day
First name	Telephone 1
Email	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	Date of birth Year Month Day
Dependent child: Last name	
First name	Date of birth Year Month Day
Dependent child: Last name	
First name	Date of birth Year Month Day
Dependent child: Last name	
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 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

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
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$
TOTAL (CAD) :				\$

Please use a separate sheet if needed.