

# TRIP CANCELLATION & INTERRUPTION INSURANCE CLAIM FORM

TIC Claims Department  
1200 – 438 University Avenue  
Toronto, Ontario, Canada M5G 2K8  
Collect worldwide: 416-340-8809  
Toll free Canada/U.S.A.: 1-800-869-6747

## INSTRUCTIONS

### IMPORTANT

- Please refer to the claims procedures in the policy booklet or your agent for details on what is required to substantiate your claim
- All claims must be reported within 30 days of occurrence.
- Written proof of claim must be submitted within 90 days of occurrence.
- Claims cannot be processed until complete documentation and a fully completed claim form is received by TIC Travel Insurance Coordinators Ltd. (TIC). Incomplete forms will be returned and will delay processing of your claim.
- You are responsible for any fees charged for completing this form or issuing supporting documentation.
- This form must be completed by the insured or by a parent or legal guardian if the insured is a minor.

### REQUIREMENTS FOR PRIOR TO DEPARTURE

- Fully completed Trip Cancellation & Interruption claim form as well as **Trip Cancellation & Interruption Insurance Medical Certificate**.
- Copy of death certificate, if applicable.
- Copy of itemized invoice showing amount paid for your trip, including airfare, hotel, taxes, service fees and any other expenses.
- Proof of payment (copy of credit card statement, cancelled cheques or receipt from travel supplier).
- Original unused travel documents (airline tickets, cruise vouchers, rail passes, etc.) if you did not get a refund from any other source.
- If you received a partial refund from a travel supplier, provide a copy of the statement showing the refund received.

### REQUIREMENTS FOR AFTER DEPARTURE

- Fully completed Trip Cancellation & Interruption claim form as well as Trip Cancellation & Interruption Medical Certificate.
- Copy of death certificate, if applicable.
- Passenger coupon from new ticket purchased to return home, with receipt showing the amount paid.
- Original receipts for any out-of-pocket expenses relating to the cancellation, if applicable (ie: Hotel, meals, taxi).
- If only a change fee was charged, receipt showing the amount charged.
- For unused tour, provide a copy of the original invoice showing breakdown of unused tour cost and copy of travel itinerary.

## SECTION A: CLAIMANT INFORMATION

Insured's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Male  Female Date of Birth: **MM/DD/YYYY** \_\_\_\_\_  
2nd Insured's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Male  Female Date of Birth: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_  
Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Destination: \_\_\_\_\_  
Scheduled Date of Departure: **MM/DD/YYYY** \_\_\_\_\_ Scheduled Date of Return: **MM/DD/YYYY** \_\_\_\_\_

## SECTION B: TYPE OF LOSS

Please indicate the general nature of the loss being claimed for:  Trip Cancellation  Interruption  Delay

If loss is due to **sickness**, please provide details:

Date symptoms first appeared: **MM/DD/YYYY** \_\_\_\_\_ Date sickness diagnosed: **MM/DD/YYYY** \_\_\_\_\_

If loss is due to **injury**, please provide details:

Date of injury/accident: **MM/DD/YYYY** \_\_\_\_\_ Describe how the injury/accident occurred: \_\_\_\_\_  
\_\_\_\_\_

If loss is due to **death**, please provide details:

Date of death: **MM/DD/YYYY** \_\_\_\_\_ Cause of death: \_\_\_\_\_

Your relationship to sick, injured or deceased person: \_\_\_\_\_

Name of patient or deceased: \_\_\_\_\_

**Name and Address of patient's usual Family Physician** Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

**Name and Address of any other physician who may have treated the patient in the last 12 months**

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

If loss is due to **other circumstances**, please provide description of loss: \_\_\_\_\_  
\_\_\_\_\_

Date the loss first occurred: **MM/DD/YYYY** \_\_\_\_\_ Date you cancelled with travel agent/travel supplier: **MM/DD/YYYY** \_\_\_\_\_

## SECTION C: EXPENSES CLAIMED

Amounts paid by you will be reimbursed to you, if claim is eligible.  
You are financially responsible for any expenses not covered by your insurance.

Type of Expense Incurred (airline ticket, hotel, etc.)	Date Incurred	Amount Paid	Currency	Amount Reimbursed/Refunded by Travel Agent or Supplier
1.	MM/DD/YYYY			
2.	MM/DD/YYYY			
3.	MM/DD/YYYY			
4.	MM/DD/YYYY			
5.	MM/DD/YYYY			

## SECTION D: OTHER INSURANCE COVERAGE

What method of payment was used to purchase the pre-paid travel arrangements?  Cash  Cheque  Credit Card

If paid by credit card, benefits may be available through the card. Please provide the following:

Name and address of issuing bank for credit card Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

First 6 digits of credit card #: \_\_\_\_\_ Expiry Date: MM/DD/YYYY

Cardholder's Name (please print): \_\_\_\_\_ Cardholder Signature: \_\_\_\_\_

Do you have insurance benefits available through homeowner's insurance, automobile insurance or any other source?

Yes  No If 'Yes', provide details below.

Plan	Name and Address of Insurance Company	Policy #	Telephone #
Homeowners Insurance			( )
Tenants Insurance			( )
Travel Insurance other than TIC			( )
Other			( )

Have you claimed from any other party?

Yes  No If 'Yes', please attach a copy of their settlement or denial.

If the loss was not reported, please provide explanation: \_\_\_\_\_

Insured's Signature: \_\_\_\_\_ Date: MM/DD/YYYY

## SECTION E: AUTHORIZATION AND CERTIFICATION

TIC is committed to protecting the privacy, confidentiality and security of the personal information we collect, use and disclose. Your personal information will be used only for the purpose of providing you with the requested insurance services. For a copy of TIC's privacy policy, please contact us.

I authorize any doctor, hospital or facility providing medical or health-related services, and any other insurer to release and exchange with TIC or its representatives, any information that is required to process this claim. I assign to TIC, any benefits payable from any other sources for losses covered under this policy, and I authorize and direct such payors to forward payment directly to TIC. I also authorize any third party providing me with assistance in this claims process, to have access to any and all relevant claims information related to the adjudication of my claim with TIC. I confirm I am authorized to act on behalf of my dependants for these purposes. A photocopy of this authorization shall be as valid as the original. I certify that the information provided in connection with this claim is complete, true and accurate.

Full Name of Patient (please print): \_\_\_\_\_

I authorize (insured's name) \_\_\_\_\_ to have access to any and all relevant claims information, including medical records, related to the adjudication of this claim.

Signature of Patient: \_\_\_\_\_ Date: MM/DD/YYYY

I authorize payment of this claim to (print name): \_\_\_\_\_

Signature of Insured (if minor, signature of parent or legal guardian): \_\_\_\_\_

Signature of policy holder of other insurance in Section D (if applicable): \_\_\_\_\_

# TRIP CANCELLATION & INTERRUPTION INSURANCE MEDICAL CERTIFICATE

TIC Claims Department  
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**NOTE:** This certificate is to be fully completed and signed by the licensed medical physician who treated the injury/sickness resulting in this claim. Any fee for the completion of this form is the patient's responsibility.

Patient's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: **MM/DD/YYYY** \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of traveller, if different from patient: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Diagnosis/condition resulting in claim: \_\_\_\_\_

Date symptoms first appeared: **MM/DD/YYYY** \_\_\_\_\_ Date of first medical consultation: **MM/DD/YYYY** \_\_\_\_\_

Date investigative testing began: **MM/DD/YYYY** \_\_\_\_\_ Date condition diagnosed: **MM/DD/YYYY** \_\_\_\_\_

Date patient made you aware of travel plans: **MM/DD/YYYY** \_\_\_\_\_

Are you the patient's usual family physician?  Yes  No

If 'No', please provide name, address and telephone number for patient's usual family physician:

**Name:** \_\_\_\_\_

**Address and Telephone #:** \_\_\_\_\_

Has the patient suffered from this medical condition in the past?  Yes  No

If 'Yes', please list below the patient's history of this condition and other related conditions over the 12 months prior to this visit:

Date of Consultation	Symptoms Exhibited/Diagnosis	Treatment Rendered
<b>MM/DD/YYYY</b>		
<b>MM/DD/YYYY</b>		

Please provide a list of the patient's current prescription medications: \_\_\_\_\_

Was the condition related to alcohol, misuse of drugs, or self-inflicted injury?  Yes  No If 'Yes', please provide details: \_\_\_\_\_

Was the patient hospitalized?  Yes  No Admission Date: **MM/DD/YYYY** Discharge Date: **MM/DD/YYYY**

Name of Hospital: \_\_\_\_\_

Was the visit related to pregnancy?  Yes  No If 'Yes', please provide specific details: \_\_\_\_\_

Date of last Menstrual Period: **MM/DD/YYYY** Expected Delivery Date: **MM/DD/YYYY**

Please provide the name and phone number of any other physicians who treated the patient, or referred the patient to you:

**Name:** \_\_\_\_\_

**Address and Telephone #:** \_\_\_\_\_

Date the patient was assessed as unfit to travel: **MM/DD/YYYY** Date you advised traveller not to travel: **MM/DD/YYYY**

## PHYSICIAN'S CERTIFICATION AND SIGNATURE

I certify that the information provided in this section is complete, true and accurate to the best of my knowledge and belief.

Physician's Signature: \_\_\_\_\_

Physician's Name (please print): \_\_\_\_\_

Date: **MM/DD/YYYY** Email: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

**PHYSICIAN'S STAMP HERE**