

# BAGGAGE 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

- 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 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.
- Please refer to the claims procedures in the policy booklet or your agent for details on what is required to substantiate your claim.
- This form must be completed by the insured or by the parent or legal guardian if the insured is a minor.

### REQUIREMENTS FOR PRIOR TO DEPARTURE

- Please enclose original receipts to substantiate ownership. Photocopies will not be accepted.
- You must provide an official loss report to validate your claim.

## 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: \_\_\_\_\_ Departure Date: **MM/DD/YYYY** Return Date: **MM/DD/YYYY**

## SECTION B: TYPE OF LOSS

- Lost  Damage  Theft  Delay

Describe how and where the loss occurred: \_\_\_\_\_

Date loss occurred: **MM/DD/YYYY** To whom was loss reported? \_\_\_\_\_

- Airline  Cruise Line  Bus Line  Tour Guide  Hotel  Police  Other (Please specify) \_\_\_\_\_

## SECTION C: SCHEDULE OF ITEMS LOST, DAMAGED, STOLEN OR DELAYED

Attach separate sheet if needed.

Description of Item Claimed	Quantity	Owner of the Item	Date Purchased	Purchase Price CAD Funds	Estimated Repair Cost or actual Cash Value
1.			<b>MM/DD/YYYY</b>		
2.			<b>MM/DD/YYYY</b>		
3.			<b>MM/DD/YYYY</b>		
4.			<b>MM/DD/YYYY</b>		

## SECTION D: OTHER INSURANCE COVERAGE

How did the insured pay for the items being claimed for?  Cash  Cheque  Credit Card

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

**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 you did not report the loss, please provide an 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 other insurer to release and exchange with TIC or its representatives any information that the insurer requires 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 Insured (please print): \_\_\_\_\_

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

Date: **MM/DD/YYYY**

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

*Signature of policyholder of other insurance specified in Section D (if applicable):* \_\_\_\_\_