Allianz
Global Assistance

TRIP CANCELLATION / TRIP INTERRUPTION / TRIP DELAY CLAIM FORM

Trip Cancellation (prior to departure), Interruption (Return early) or Delay (beyond scheduled return date)

CLAIM MUST BE FILED WITHIN 90 DAYS OF INCIDENT.

Along with your completed and signed claim form, please provide the following documentation. Failure to provide the documentation requested will result in a delay of our claims adjudication.

- ☐ If your insurance is through your credit card provider, please provide a copy of your monthly billing statement, confirming the payment of your trip. Please ensure that the last four digits of your credit card number are visible for verification of coverage.
- ☐ A copy of your complete travel itinerary which includes passenger names, dates of travel and trip amounts.
- ☐ Documentation confirming any refunds from any other insurance/travel supplier or airline that you have received.
- ☐ A copy of all invoices for any additional pre-paid trip arrangements, such as hotels, cruise, car rentals.
- ☐ If you are claiming for trip cancellation due to a medical reason please have the primary care physician of the patient complete section four of the claim form or provide a copy of the death certificate, if applicable.
- ☐ If you are claiming for trip interruption or delay due to a medical emergency please have the physician who recommended your interruption or delay complete section four of the claim form or provide a copy of the death certificate, if applicable.
- ☐ If the reason for your cancellation/interruption/delay is non-medical, please provide documentation to confirm the reason for the claim such as a subpoena to appear in court, your record of employment, a copy of travel advisory.

FREQUENTLY ASKED QUESTIONS:

1. Why is my doctor required to provide information and sign a section of this claim form? (Trip Cancellation)

A medical doctor must recommend you cancel your trip. You will need to have the attending physician complete the medical section of the claim form or submit a letter containing all pertinent information, to validate your claim.

2. **Why do I need a note from a doctor at my destination? (Trip Interruption / Trip Delay)**

   If a medical situation requires that you interrupt or delay the return from your trip, you will need to have the attending physician at your destination submit a letter containing all pertinent information, to validate your claim. The letter must contain the following:
   - Diagnosis
   - Date(s) of doctor's visit or hospitalization
   - Reason for interruption or delay

3. **What do the terms "Non-transferable" and "Non-refundable" mean?**

   A non-transferable ticket cannot be used by any person other than the named passenger on the ticket. It may however be possible to change the travel dates on a non-transferrable ticket. A non-refundable ticket cannot be returned for a refund but it may be possible to change the travel dates. Refer to your booking or travel agent to confirm the specific details of your ticket.

Return Claim Form and Documents to:
submit@allianz-assistance.ca

Allianz Global Assistance
P.O. Box 277
Waterloo, ON
N2J 4A4
Fax: 519-742-9471

TRIP CANCELLATION/INTERRUPTION/DELAY CLAIM FORM

(Check one) I am claiming for: ☐ **Trip Cancellation** ☐ **Trip Interruption** ☐ **Trip Delay**

Please print unless otherwise indicated

SECTION 1: ACCOUNT INFORMATION

Case # (if applicable): ______________

Name: ____ Date of Birth (MM/DD/YY): __________________

Street: ____

City: ____ Province: ________________ Postal Code: ____________

Home Phone: ______________________ Business Phone :(   )_______________

E-mail: ____

Policy Number ____ (if credit card number please only list last four digits)

Name as it appears on this card _______________________ Date of Birth of this card holder (MM/DD/YY): _____________

Issuing Bank: ______________________________

Which card was the purchase made on? ☐ Primary Card ☐ Secondary Card, if you are the secondary please provide the Primary Cardholders: Name: ______________________________ Date of Birth: ______________________

Address (if different): ____

SECTION 2: TRAVEL DETAILS

Original Planned Departure Date: _____________ (MM/DD/YY) Original Planned Return Date: ______________ (MM/DD/YY)

Actual Return Date: ______________ (MM/DD/YY)

Nature of Travel: ☐ Business ☐ Leisure ☐ Other Mode of Travel: ☐ Car ☐ Airplane ☐ Other

Date of Initial trip deposit: _______________ (MM/DD/YY) Date of final payment: ________________ (MM/DD/YY)

Date of Incident (Cancellation/Interruption/Delay): ______________ (MM/DD/YY)

Describe in detail the cause and circumstances related to this claim: ____

____

____

SECTION 3: CLAIM SUMMARY

Total number of claimants: __________ Relationship to policyholder: ____

	Amount	Currency	
Transportation Expenses including taxes (air fare etc.)	______________	__________	Attach proof of payment and non-refundable amounts, along with documentation stating cancellation or interruption penalties.
Accommodation and meal Expenses (receipts required)	______________	__________	
Other Expenses	______________	__________	
	______________	__________	
Total Expenses Paid	______________	__________	
Total Refund	______________	__________	Refund from travel agent/airline/other
Amount of Claim	______________	__________	Total expenses less refund amount

Please have this section completed by a physician:

SECTION 4: MEDICAL INFORMATION

Patient's Name: ______________________________ Patients Relationship to Insured: ________________________________

Patient's Date of Birth: (MM/DD/YY):______________________ (If the patient is an insured person under this plan)

Medical reason for claim: ______________________________Date Symptoms first noted (MM/DD/YY):_____________________

Is this a new condition? ☐ Yes ☐ No If No, what date was this condition first diagnosed (MM/DD/YY): ________________

Date of first doctor visit for present onset (MM/DD/YY): ____

Has the patient received treatment or advice for this condition in the past year? ☐ Yes ☐ No

If YES, please provide all dates (MM/DD/YY):

____

Does the patient take ongoing medication for this condition? ☐ Yes ☐ No

If YES, please provide names: ____

When was the medication last altered? (MM/DD/YY) _________________ Why? _____________________________________

If patient was referred to you, provide name and phone number of referring physician:

____ Date of referral (MM/DD/YY)

____

Were any follow up treatments required? ☐ Yes ☐ No If YES, please specify dates (MM/DD/YY): ________________

Was the patient hospitalized? ☐ Yes ☐ No If YES, from (MM/DD/YY) ________________ to ________________

Name of hospital: ____

If condition was due to pregnancy, please provide:

Date of confirmation of pregnancy: (MM/DD/YY) ________________ Expected date of delivery: (MM/DD/YY) ________________

Is the Patient a traveller? ☐ Yes ☐ No. If yes, did you advise the patient to cancel his/her travel plans? ☐ Yes ☐ No

Date advised not to Travel? (MM/DD/YY) ____________________

Patient was not fit to travel from (MM/DD/YY) ____________________ to _____________________

<u>Certification</u>

Your certification will establish the validity of the claim. Please complete fully.

According to my records, the above information is true and correct. I also agree that I may be contacted for additional information regarding the above patient, including sending copies of medical records if needed.

Name of the attending physician: ____

Address: ____

City: ____________________________________ Province/State: _________________________ Country: _________________

Postal Code/Zip Code: ______________________ Telephone: _________________________

Signature of Attending Physician: ____ Date: ___________________________

If different from above: Name of Family Physician: __________________________________ Telephone: _________________

Address: ____

SECTION 5: OTHER INSURANCE COVERAGE

Please indicate all insurance coverage you (or the patient) may have through any other insurer, including employer group benefits, union or pensioner plans or other travel insurance policies. Attach an additional page if required.

1) Name of Insurer: ____ Phone:________________________________

Address____

Lifetime limit on policy? ☐ No ☐ Yes (specify) $___________ Policy #____________Certificate #____________

Name of Policyholder: _________________________ Signature of Policyholder: ___________________________

2) Name of Insurer: ____ Phone:________________________________

Address____

Lifetime limit on policy? ☐ No ☐ Yes (specify) $___________ Policy #____________Certificate #____________

Name of Policyholder: _________________________ Signature of Policyholder: ___________________________

Have these bills been filed with any other company? ☐ No ☐ Yes (specify)

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SECTION 6: IMPORTANT, PLEASE READ AND SIGN

CERTIFICATION: The undersigned hereby certifies that the information provided by him or her on this form and otherwise in support of this claim is complete and accurate to the best of each of his or her knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be void, payment of this claim denied and any claim payments made in error recovered. The undersigned agrees to refund the amount of any payments that should not have been made.

PERSONAL INFORMATION NOTICE: The information provided with respect to this claim is required by the insurer and its authorized administrator, Allianz Global Assistance, and any insurance adjuster appointed to investigate any losses on its behalf (collectively "we" "us" "our") for insurance purposes, such as to assess any entitlement to benefits and to administer this claim. We will investigate and administer this claim by consulting the insurer's existing files and by exchanging additional information[1] with the undersigned and third parties, such as law enforcement, fire and emergency services departments, parties involved with any subrogation action, and other independent sources. **ALL REQUIRED INSURANCE, POLICE, CLAIM FORMS AND REPORTS MUST BE PROVIDED TO US BEFORE YOUR CLAIM CAN BE PROCESSED.**

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize any physician, hospital or other medical provider who has attended or examined me to release to and exchange with Allianz Global Assistance or its representatives any and all information[1] regarding my medical history, symptoms, treatment, examination or diagnoses for the purpose of adjudicating my claim.

Primary Cardholder/Subscriber (please print) ________________________________

Signature of Primary Cardholder/Subscriber: ________________________________ Date signed: ___________________
(MM/DD/YY)

Patient Signature: _____________________________________ Date signed: ___________________
(MM/DD/YY)

CLAIM MUST BE FILED WITHIN 90 DAYS OF INCIDENT.

Completed and signed claim forms and supporting documents should be returned to Allianz Global Assistance within 90 days from the date of incident. Prompt attention to this request for information is required to adjudicate your claim.

Please note that photocopies and scanned images are acceptable. However, it is your responsibility to keep the originals for one year after payment as we reserve the right to audit and ask for the originals to be sent to us during that time.

Should you choose to submit original documents they will not be returned upon completion of your claim.

[1] IMPORTANT: Personal information excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.