FLIGHT ACCIDENT AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE CLAIM FORM

TIC Claims Department
2100 – 250 Yonge Street
Toronto, Ontario, Canada M5B 2L7
Collect worldwide: 416-340-8809
Toll free Canada/U.S.A.: 1-800-869-6747

INSTRUCTIONS

IMPORTANT

- Written proof of claim must be submitted within 90 days of occurrence.
- You are responsible for any fees charged for completing this form or issuing supporting documentation.
- Please refer to claims procedures in the policy booklet.

REQUIREMENTS FOR FLIGHT ACCIDENT

- Fully completed and signed claim form completed by either the insured person or in the case of death, by the appointed executor/executrix.
- Copy of flight itinerary.
- Copy of incident report from airline or airport.
- Copies of all hospital/medical reports (if applicable).
- Death certificate in the event of death.

REQUIREMENTS FOR ACCIDENTAL DEATH & DISMEMBERMENT

- Fully completed and signed claim form completed by either the insured person or in the case of death, by the appointed executor/executrix.
- Police report including any witness' statements.
- Coroner's report and autopsy report.
- Death Certificate.
- Copies of all hospital/medical reports (if applicable).

SECTION A: CLAIMANT INFORMATION

Insured's First Name: _____ Last Name: _____

Male Female Date of Birth: MM / DD / YYYY _____

Policy #: _____ Telephone: ( ) _____ Fax: ( ) _____

Email: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Destination: _____

Departure Date: MM / DD / YYYY _____ Return Date: MM / DD / YYYY _____

SECTION B: DETAILS OF ACCIDENT

How did the accident occur? _____

When did the accident occur? MM / DD / YYYY _____ Time: _____ am / pm

Where did the accident occur? _____

SECTION C: MEDICAL INFORMATION

Cause of Death (if applicable): _____

Details of injury(s) causing dismemberment: _____

SECTION C: MEDICAL INFORMATION – CONT'D

Please provide attending doctor's name and telephone #:

Please provide the name of your usual family physician:

Telephone: ( ) Fax: ( )

Address:

City: Province: Postal Code:

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

SECTION D: THIRD PARTY LIABILITY

Was the accident as a result of negligence of another person or entity? Yes No If 'Yes', please provide full details:

Name:

Address:

City: Province: Postal Code:

Telephone: ( ) Policy #:

Please provide the following information if your claim relates to a motor vehicle accident.

Name of auto insurance company:

Address:

City: Province: Postal Code:

Telephone: ( ) Policy number with auto insurance company:

Please provide the following information if your claim relates to an airflight accident.

Name of airline carrier:

Name of Airline Insurance carrier:

Address:

City: Province: Postal Code:

Telephone: ( )

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): Date: MM/DD/YYYY

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

Signature of Insured or authorized representative (if minor, signature of parent or legal guardian):