TO SUBMIT A CLAIM

Trip Cancellation and Interruption

HERE ARE THE STEPS TO SUBMIT A CLAIM

Step 1 . . . . . Gather all your detailed original receipts, boarding passes, detailed proof of payment and any other relevant documents.

Step 2 . . . . . Ask your travel service provider for a proof of partial or total reimbursement. If no reimbursement was issued, ask for written proof.

Step 3 . . . . . Complete and sign the *Claim and Authorization Form for Trip Cancellation and Interruption*.

Step 4 . . . . . Ask the doctor in charge of the person whose condition was the cause of this claim to fill out, sign, and stamp the Medical Certificate.

CHECKLIST

Have you:

- ☐ Attached all original receipts, boarding passes, proof of payment and other relevant documents?
  Photocopies will not be accepted.
- ☐ Attached a proof of partial or total reimbursement, or a proof that no reimbursement was issued?
  Failure to provide this document will delay your claim assessment.
- ☐ Completed and signed the *Claim and Authorization Form for Trip Cancellation and Interruption* ?
  All incomplete forms will be returned and will delay your claim assessment.
- ☐ Attached the Medical Certificate filled out, signed, and stamped by the doctor in charge of the person whose condition was the cause of this claim?
  Failure to provide this document will delay your claim assessment.

IMPORTANT NOTES

- All aforementioned documents must be received within 90 days of your return to your province of residence.
- Any fees for the completion of medical certificates or claim forms are your responsibility.

SEND ALL YOUR DOCUMENTS TO:
LS-Travel Att. Claims Department 247 Thibeau Boulevard Trois-Rivières (Québec) G8T 6X9
To verify your claim status
Toll free: 1-877-344-8398 Email: claimsfollowup@tourmed.ca

247 Thibeau Blvd., Trois-Rivieres (Quebec) G8T 6X9
Telephone: 1 877 344-8398, Fax: 1 819 377-6069

CLAIM AND AUTHORIZATION FORM FOR TRIP CANCELLATION AND INTERRUPTION

CLAIMANT INFORMATION

Applicant 1

_____ Date of birth: _____ Sex: M ☐ F ☐
Last Name First Name mm / dd / yyyy

Applicant 2

_____ Date of birth: _____ Sex: M ☐ F ☐
Last Name First Name mm / dd / yyyy

Email: _____

Address: _____ Apt.: _____

City: _____ Province: _____ Postal Code: _____

Home phone: _____ Business phone: _____ Extension: _____

Destination: _____

Schedule date of departure: _____ Schedule date of return: _____ **POLICY #:** _____
mm / dd / yyyy mm / dd / yyyy

TYPE OF LOSS

Please indicate the reason for which you are submitting a claim:

Trip Cancellation ☐ Interruption ☐ Delay ☐

Describe the circumstances which resulted in cancellation or interruption of your trip.

_____

_____

Instructions: Please complete appropriate sections according to type of loss: ***Sickness (1+4), Injury (2+4), Death (3+4), Other circumstances (5)***

Section 1

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

Date symptoms first appeared: _____ Date sickness was diagnosed: _____
mm / dd / yyyy mm / dd / yyyy

Section 2

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

Date of injury / accident: _____
mm / dd / yyyy

Describe how the injury / accident occured: _____

_____

Section 3

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

Date of death: _____ Cause of death: _____
mm / dd / yyyy

Section 4

Name of sick, injured or deceased person: _____ Your relationship to that person: _____

Name of patient's usual Family Physician: Name: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Telephone: _____

Section 5

If loss is due to **other circumstances**, please provide details: _____

_____

Date of the cause of cancellation or interruption: _____
mm / dd / yyyy

Date of notification to the travel agent: _____
mm / dd / yyyy

(CONTINUED ON FOLLOWING PAGE)

EXPENSES CLAIMED (Provide all original invoices.)

Type of expenses incurred (Airline ticket, hotel, etc.)	Date incurred mm / dd / yyyy	Amount paid	Currency	Amount reimbursed / refunded by Travel Agent or Supplier

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

OTHER INSURANCE COVERAGE

Do you have group benefits through (check all that apply and provide details):

your Employer ☐ your Spouse's Employer ☐ a Retiree Plan ☐ None ☐

Name of Plan Member / Employee / Retiree: _____ Date of birth: _____ mm / dd / yyyy

Name of Employer / Group: _____ ID # (Employee #, Certificate #, etc.): _____

Name & address of Insurance Company: _____

Do you have other travel insurance? Yes ☐ No ☐

Name of Insurance Company: _____ Policy / ID #: _____

Do you have a credit card? Yes ☐ No ☐

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

Name of Financial Institution: _____ Card #: _____

AUTHORIZATION AND CERTIFICATION

I assign to LS-Travel any indemnity obtainable from other sources for covered losses under this policy. I also direct these sources to forward payment to LS-Travel for my claims submitted with regard to these losses and to exchange information that facilitates this process.

I authorize any hospital, physician or medical facility to send my medical information to LS-Travel. I further consent to the disclosure of this information by LS-Travel to other sources as may be required to obtain benefits from other sources.

I warrant the neither I nor any insured person have any additional coverage through any other insurer (other than listed above).

I understant that my insurance shall be void if, whether before or after the loss, any person has concealed or misrepresented any fact or circumstances concerning this claim.

A photocopy or faxed copy 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): _____
(If differs from Applicants 1-2)

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

Signature of applicant 1: _____ **Date :** _____ mm / dd / yyyy

Signature of applicant 2: _____ **Date :** _____ mm / dd / yyyy

For claim inquiries, call LS-Travel: 1 877 344-8398