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

CLAIM AND AUTHORIZATION FORM FOR TRIP CANCELLATION AND INTERRUPTION

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

PARTICIPANT INFORMATION

Participant

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

Name of the employer: ____________________

Email: ____________________

Address: ____________________ Apt.: __________

City: ____________________ Province: __________ Postal Code: __________

Home phone: ____________________ Business phone: ____________________ Extension: __________

Destination: ____________________

Schedule date of departure: __________ Schedule date of return: __________ **CONTRACT #**: __________
mm / dd / yyyy mm / dd / yyyy

Dependants

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

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

TYPE OF LOSS

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

Trip Cancellation ☐ Interruption ☐

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 other travel insurance through (check all that apply and provide details):

☐ private insurance

Name of Insurance Company: ____________________ Policy #: ____________

☐ credit card

Name of Financial Institution: ____________________ Card #: ____________

☐ None

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 claimant (please print): ______________________________
(if different than the participant)

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

Signature of claimant (if has reached age of majority): ____________________ **Date :** ____________
mm / dd / yyyy

Signature of participant: ____________________ **Date :** ____________
mm / dd / yyyy

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