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

LS insurance company Travel

COLLECT COLLECT Total

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

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 hereby assign to LS-Travel, Insurance Company, (hereinafter "Insurer") any benefits obtained from other sources, including but not limited to, insurance companies, airlines, travel agencies, and any other source, for losses covered under this policy. I also direct these sources to transmit payment to the *Insurer* for my claims submitted by the *Insurer* with regard to these losses and authorize all sources and the *Insurer* to communicate all relevant information to facilitate the claims process.

I hereby authorize LS-Travel, Insurance Company, to collect, by any electronic means, email, fax or mail, and to use, any medical or non-medical information about me held by, including but not limited to, any licensed physician, practitioner, hospital or medical institution, insurance company, or any other organization, agency, institution, company or person (hereinafter "Third Parties") who has information or documents relevant to the analysis of any claim submitted under this insurance policy. I understand that this information could also be communicated to these Third Parties, whether in or outside of my province of residence. In the event of a claim, I also authorize the *Insurer* to collect, from my *Representative*, any telephone conversation recorded during the application process.

If, for any reason, I do not authorize LS-Travel, Insurance Company, to collect and use this information, I understand that my benefits could be reduced or limited, according to the terms and conditions of the policy. A photocopy or facsimile of this authorization is accepted and recognized as valid as the original or a true copy thereof.

I declare that I am aware of the rights granted by the "Act Respecting the Protection of Personal Information in the Private Sector", including but not limited to the right to access my information, the right to have that information corrected, if need be, and the right to withdraw, at any time, this authorization to share and use my personal information.

I certify that I have no other insurance coverage than the ones mentioned in this claim form.

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

I certify that the statements given in the making of this claim are complete, true, and accurate to the best of my knowledge.

A photocopy, facsimile or electronic copy of this authorization shall be considered as effective and valid as the original or a true copy thereof.

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

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- Please provide legible documents. Photographs and pictures will not be accepted.

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