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

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

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

7500-164 EN- Rév. 09/2023

MEDICAL CERTIFICATE
TRIP CANCELLATION AND INTERRUPTION INSURANCE

LS-Travel
247 Thibeau Blvd., Trois-Rivieres (Quebec) G8T 6X9
Telephone: 1-877-344-8398 or 1-819-377-1777, Fax: 1-819-377-6069

ATTENDING PHYSICIAN'S CERTIFICATE

The licensed medical physician who treated the injury / sickness resulting in this claim must complete this certificate in full for all clinic, office, out-patient and short duration emergency room visits. Any fee for the completion of this form is the patient's responsibility.

DOCTOR: Your certificate will establish the validity of the claim. Please complete fully. Applicable to the person whose condition was the cause of this claim.

Patient's Name: _____ Date of birth: _____ mm / dd / yyyy

Relationship to Insured: _____

Patient's Address: _____

Insured's Name: _____ Policy #: _____

Diagnosis related to claim: (List in order of severity)

1. _____
2. _____
3. _____

Date symptoms first appeared: _____ mm / dd / yyyy

Date of first medical consultation for present onset: _____ mm / dd / yyyy Date condition diagnosed: _____ mm / dd / yyyy

Is this a new condition? Yes ☐ No ☐

If "No", on what date was this condition first diagnosed? _____ mm / dd / yyyy

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

If "Yes", please provide all dates: _____

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

If "Yes", please provide all names: _____

When was the medication last altered? _____ mm / dd / yyyy

Why? _____

Date medication first prescribed? _____ mm / dd / yyyy

Are you the patient's usual family physician? Yes ☐ No ☐

If "No", please provide name, address and telephone number for patient's usual family physician:

Name: _____

Address and telephone #: _____

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

_____

Did the patient make you aware of travel plans? Yes ☐ No ☐ If "Yes", specify when: _____ mm / dd / yyyy

Did the patient receive medical approval from you for the trip? Yes ☐ No ☐

If condition was due to pregnancy, what was the expected date of delivery: _____ mm / dd / yyyy

(CONTINUED ON FOLLOWING PAGE)

ATTENDING PHYSICIAN'S CERTIFICATE (continued)

If condition was due to accident, what was the date of occurence: _____
mm / dd / yyyy

Were follow up treatments required? Yes ☐ No ☐ Please specify dates: _____

Was the patient hospitalized? Yes ☐ No ☐ From _____ To _____
mm / dd / yyyy mm / dd / yyyy

Name of hospital: _____

Was the condition related to alcohol, misuse of drugs (prescription), or self-inflicted injury? Yes ☐ No ☐

If "Yes", please provide details: _____

In your professional opinion, from what date did this condition preclude travel for the patient or a family member? _____
mm / dd / yyyy

On what date was the patient or family member advised to cancel the trip? _____
mm / dd / yyyy

If the two previous dates are different, please explain why: _____

Comments: _____

_____

_____

PHYSICIAN'S CERTIFICATION AND SIGNATURE

I certify that the information provided in this section is complete, true and accurate to the best of my knowledge and belief.

Name of Attending Physician (please print): _____

Address: _____ City: _____

Province: _____ Country: _____ Postal Code: _____

Telephone: _____ Fax: _____

Email: _____

ATTENDING PHYSICIAN'S STAMP OR ATTACH LETTERHEAD OR PRESCRIPTION PAD

Signature of Attending Physician: _____ Date: _____

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