

CLAIMANT INFORMATION

Applicant 1

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

Applicant 2

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

Email: _____

Address: _____ Apt: _____

City: _____ Province : _____ Postal code: _____

Home phone: _____ Business phone: _____ Extension: _____

Destination: _____

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

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 / 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: _____ mm / dd / yyyy Date sickness was diagnosed: _____ 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 occurred: _____

Section 3
If loss is due to **death**, please provide details:
Date of death: _____ mm / dd / yyyy Cause of death: _____

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 / interruption : _____ mm / dd / yyyy Date travel agent notified: _____ mm / dd / yyyy

EXPENSES CLAIMED

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 Tour+Med/LS-Travel any indemnity obtainable from other sources for covered losses under this policy. I also direct these sources to forward payment to Tour+Med/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 Tour+Med/LS-Travel. I further consent to the disclosure of this information by Tour+Med/LS-Travel to other sources as may be required to obtain benefits from other sources.

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

I understand 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): _____

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