



BEFORE submitting your claim with regard to COVID-19, have you read and confirmed that your claim did not need to be submitted to your credit card insurer first (*see Instruction sheet - with regard to COVID-19 on our website*)?

All requests that should have been presented to the aforementioned in the first place will be returned. Also note that if you submit an incomplete file, it will not be treated.

TO SUBMIT A CLAIM

Trip Cancellation and Interruption with regard to COVID-19

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 If you have booked your trip using a credit card, ask for a proof of partial or total reimbursement from the issuing company, or provide proof that your credit card does not provide any Trip Cancellation and Interruption Insurance.

Step 4 Fill out and sign the Claim Form.

CHECKLIST

Have you attached:

- All original invoices;
- Proofs of payments made (credit card statement, bank account statement, copy of the two-sided cashed cheque, receipt from the credit or debit card);
- Credit card statement confirming which card was used and showing relevant expenses paid with that card, as well as refunds if applicable;
- Written confirmation of the cancellation date from each service provider;
- Written confirmation of the applicable penalty from each service provider;
- Written proof of the refusal to pay from your credit card insurer, if applicable;
- Proof of the refund from each service provider;
- Unused tickets and vouchers;
- All other relevant documents.

IMPORTANT NOTES

- All aforementioned documents must be received within 90 days of your trip cancellation or interruption. (Exceptions: requests that need to be submitted to the credit card insurer first.)
- Any fees charged to obtain proofs and documents 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

Email: claimsfollowup@tourmed.ca
Toll free: 1-877-344-8398



CLAIM AND AUTHORIZATION FORM FOR TRIP CANCELLATION AND INTERRUPTION WITH REGARD TO COVID-19

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

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: _____ App.: _____

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 #:** _____

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

Date of notification to the travel agent: _____ 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.

INFORMATION ABOUT THE TRANSACTION

Date of invoice: _____ mm / dd / yyyy Destination: _____

Amount paid: _____ Amount claimed: _____ Departure date: _____ mm / dd / yyyy Return date: _____ mm / dd / yyyy

Invoice number or reservation number (if available): _____

INFORMATION ABOUT THE TRANSACTION

Payment method

Check and fill in all that apply.

Cash

Amount _____ Name of person to whom the payment was remitted _____ Date remitted (mm / dd / yyyy) _____

Credit Card

Amount _____ Credit card number _____ Expiration date (mm / yy) _____

Name of credit card holder _____

Name of the issuing bank _____ Name of the card (you can also attach a photo of your card) _____

Cheque

Amount _____ Care of _____

Other, specify: _____

Amount _____

REIMBURSEMENT BY A THIRD PARTY

Have you filed a claim for reimbursement for the same event with an insurer, another organization, a tourism service provider or any other person, including a credit card issuer?

Yes No

If yes, please provide the following information.

Name of organization or person _____

Address _____

City _____ Province _____ Postal code _____

Telephone _____ Ext. _____ Email _____

Have you received a reimbursement (either full or partial)?

Yes, specify: _____
Amount

No

If you receive a full or partial reimbursement at a later date, regardless of the source (insurance, credit card, travel agency, tourism service provider, etc.), you agree to return that amount to LS-Travel without delay.

Yes, I agree

Signature of the applicant _____

Date (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 according to the terms and conditions of your Insurance Policy.
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 #: _____

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 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.

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