

Island Breeze Trip Cancellation & Interruption Insurance Claim Form

Instructions

Important

- Please to the claims procedures in the policy booklet or your agent for details on what is required to substantiate your claim.
- All claims must be reported within 30 days of occurrence.
- Written proof of claim must be submitted within 90 days of occurrence
- Claims cannot be processed until complete documentation and a fully completed claim form is received by Sports-Can Insurance Consultants Ltd.
- You are responsible for any fees charged for completing this form or issuing supporting documentation
- This form must be completed by the insured or by a parent or legal guardian if the insured is a minor

Requirements for Prior to Departure

- Fully completed and Trip Cancellation & Interruption claim form as well as Trip Cancellation & Interruption Insurance Medical Certificate.
- Copy of death certificate, if applicable
- Copy of itemized invoice showing amount paid for your trip, including airfare, hotel, taxes, service fees and any other expenses/
- Proof of payment (copy of credit card statement, cancelled cheques or receipt from travel supplier).
- Original unused travel documents (airline tickets, cruise vouchers, rail passes, etc.) If you did not get a refund from any other source.
- If you received a partial refund from a travel supplier, provide a copy of the statement showing the refund received.

Requirements for After Departure

- Fully completed and Trip Cancellation & Interruption claim form as well as Trip Cancellation & Interruption Insurance Medical Certificate.
- Copy of death certificate, if applicable
- Passenger coupon from new ticket purchased to return home, with receipt showing the amount paid.
- Original receipts for any out of pocket expenses relating to the cancellation, if applicable (i.e: hotel, meals taxi).
- If only a change fee was charged, receipt showing the amount charged.
- For unused tour, provide a copy of the original invoice showing breakdown of unused tour cost and copy of travel itinerary.

Section A: Claimant Information

Insured's First Name: _____ Last Name: _____

Male Female Date of Birth: MM: _____ DD: _____ YY: _____ Policy#: _____

Telephone: () _____ Fax: () _____ Email: _____

Address: _____ City: _____ Province: _____ Postal Code _____

Destination: _____ Departure Date: MM: _____ DD: _____ YY: _____

Return Date: MM: _____ DD: _____ YY: _____

Section B: Type of Loss

Please indicate the general nature of the loss being claimed for:

Trip Cancellation Interruption Delay

If the loss is due to sickness, please provide details:

Date Symptoms first appeared: MM: _____ DD: _____ YY: _____

Date Sickness Diagnosed: MM: _____ DD: _____ YY: _____

Date of injury/accident: MM: _____ DD: _____ YY: _____

How did the injury/ accident occur?

If loss is due to death, please provide details:

Date of death: MM: _____ DD: _____ YY: _____ Cause of Death: _____

Your relationship to sick, injured or deceased person: _____

Name of patient or deceased: _____

Name and address of patients usual Family Physician: Name: _____

Street Address: _____ City: _____ Province: _____ Postal code: _____

Name and address of any other Physician who may have treated the patient in the last 12 months:

Name:

Street Address: _____ City: _____ Province: _____ Postal code: _____

If the loss is due to other circumstances, please provide description of loss:

Date the loss first occurred: MM: _____ DD: _____ YY: _____

Date you Cancelled with the travel Agent/ supplier: MM _____ DD _____ YY _____

Section C: Expenses Claimed

Amounts paid by you will be reimbursed to you, if the claim is eligible.
 You are financially responsible for any expenses not covered by your insurance.

Type of Expense Incurred	Date incurred	Amount Paid	Currency	Amount Reimbursed by Travel agent/ supplier
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Section D: Other Insurance Coverage

What method of payment was used to purchase the pre-paid travel arrangements: Cash Cheque
 Credit card

If paid by credit card, benefits may be available through the card, please provide the following:

Name and Address of issuing bank from credit card: Name: _____ Postal Code: _____
 Street Address: _____ Province: _____

First 6 digits of credit card #: _____ Expiry Date: _____

Cardholders Name: _____ Signature: _____

Do you have insurance Benefits available through homeowners insurance, automobile insurance or any other source:

Yes No if yes please provide details below

Plan	Name & Address of Insurance Company	Policy #	Telephone
Homeowners Insurance			()
Tenants Insurance			()
Travel Insurance (other than Sports-Can)			()
Other			()

Have you claimed from any other party?

Yes No if yes please attach a copy of their settlement or denial

If the loss was not reported please provide an explanation:

Insured's signature

Date: MM DD YY

Section E: Authorization and Certification

Sports-Can Insurance Consultants Ltd. is committed to protecting the privacy, confidentiality and security of the personal information we collect, use and disclose, your personal information is used only for the purpose of providing you with the requested insurance services, For a copy of Sports-Can's privacy policy, please contact us.

I authorize any doctor, hospital or facility providing medical or health-related services, and any other insurer to release and exchange with Sports-Can Insurance Consultants Ltd. or its representatives, any information that is required to process this claim. I assign to Sports-Can Insurance Consultants Ltd. any benefits payable from any other sources for losses covered under this policy, and I authorize and direct such payors to forward payment directly to Sports-Can Insurance Consultants Ltd.. I also authorize any third party providing me with assistance in this claims process, to have access to any and all relevant claims information related to the adjudication of my claim with Sports-Can Insurance Consultants Ltd..

I confirm I am authorized to act on behalf of my dependents for these purposes. A photocopy of this authorization form shall be 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 (insureds 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: ____ YY: ____

I authorize payment of this claim to (please print): _____

Signature of Insured or authorized representative (if minor, signature of parent or legal guardian:

Signature: _____

Signature of policyholder of other insurance in section D (if applicable): _____