TRIP CANCELLATION, TRIP INTERRUPTION & TRAVEL DELAY CLAIM FORM

ACTIVE CARE MANAGEMENT

SECTION A – CLAIMANT INFORMATION			
Insured's Name (Last Name, First Name, Middle Initial)			
Policy Number	Date of Birth MM | DD | YYYY	Gender ☐ Male ☐ Female	
Home Address	City	Province	Postal Code
Email Address	Phone ( )	Fax ( )	

SECTION B – TRAVEL INFORMATION			
Travel Destination	Date Trip Booked MM | DD | YYYY	Original Departure Date MM | DD | YYYY	Original Return Date MM | DD | YYYY
If your claim is related to Bounceback benefit please fill in dates:	Date Returned to Canada MM | DD | YYYY	Date Returned to Destination MM | DD | YYYY	
Travel Agency Name	Phone ( )	Fax ( )	
Agency Address	City	Province	Trip Cost (CDN Funds)
Reason for trip cancellation, trip interruption or travel delay			Date of Incident MM | DD | YYYY
To whom did you notify?			Date of Notification MM | DD | YYYY
Is this claim due to the sickness/injury or death of a person other than the claimant? *If yes please answer the following:*			
Name of Sick/Injured/Deceased Person: **The physicians statement must be completed by the physician of the above named person*			*Relationship to the Claimant:*
Address of Sick/Injured/Deceased Person:	*City*	*Province*	*Postal Code*
Was person residing in nursing home or long term care facility?			

Schedule of Non-Refundable Travel Arrangements ***if more space required please attach separate page**

Supplier Name / Description	Amount Paid	Amount Refunded to you	Refunded By	Amount Claimed

Do you have any other Travel Insurance Coverage? ☐ Yes ☐ I do not have any other Travel Insurance Coverage

If yes, please list name of policy:

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SECTION C – PHYSICIAN'S STATEMENT (To be completed by physician only. *If your claim is due to sickness, injury or death you must have this section completed by the attending physician of the person whose medical condition was the cause of the cancellation or interruption.)*

Patient's Last Name	Patient's First Name	Date of Birth MM | DD | YYYY
Attending Physician Name (Last, First, Middle)		

Physician Address	City	Province	Postal Code
Email address		Phone ( )	Fax ( )

This treatment is the result of: ☐ Injury ☐ Sickness	Diagnosis

Date of first consultation: MM | DD | YYYY	Date symptoms/injury first occurred: MM | DD | YYYY	ICD Code
List all dates of examination/treatment for this condition from initial consult to present:		Date patient became medically unable to travel: MM | DD | YYYY
Has this patient ever been treated for this or a related condition? ☐ Yes ☐ No If 'Yes" list dates of treatment and diagnosis:		Expected date patient able to travel: MM | DD | YYYY
Is this condition a complication of an underlying condition? ☐ Yes ☐ No If 'Yes" please specify:		

Was patient referred to you by another physician? ☐ Yes ☐ No	Physician Name

Physician Address	City	Province	Postal Code

Injury

Is this claim the result of an injury? ☐ Yes ☐ No - *If 'No', proceed to Illness Section*	Date of Injury MM | DD | YYYY
Brief Description of accident or injury (time, location, how it occurred):	
Does this claim relate to a motor vehicle accident? ☐ Yes ☐ No - *If 'No', proceed to Illness Section*	
How and where did accident occur?	

Name of Motor Vehicle Insurance Company	Policy #		Phone ( )
Address	City	Province	Postal Code

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Illness			
Date symptoms first appeared MM | DD | YYYY	First date of treatment MM | DD | YYYY	Describe Illness	
Had the patient ever experienced this illness or a similar problem before? ☐ Yes ☐ No		Date of Previous Occurrence MM | DD | YYYY	
Treating Doctor's Name		Phone ( )	
Describe Conditions / Diagnosis			

Medical Facilities – list facility where treated and doctors consulted

Name	Address	Phone	Fax	Date
				MM | DD | YYYY
				MM | DD | YYYY
				MM | DD | YYYY
				MM | DD | YYYY

Physician's Authorization and Certification	
I certify that the information provided in this section is complete, true and accurate to the best of my knowledge and belief.	Physician's Stamp
Physician's Signature	
Date MM | DD | YYYY	

SECTION D – AUTHORIZATION

I authorize any doctor, hospital or facility providing medical or health-related services, and any other insurer to release and exchange with ACM or its representative, any information that is required to process this claim. I assign to ACM 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 ACM. 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 ACM. I confirm I am authorized to act on behalf of my dependants for these purposes. A photocopy 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.

If you authorize payment of this claim to anyone other than yourself or your provider, please provide name of recipient:

Name of Patient/Insured (Last Name, First Name, Middle Initial)	Date MM | DD | YYYY
Insured's Signature (If minor, signature of parent or legal guardian)	Date MM | DD | YYYY

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