Trip Cancellation

How to Submit a Claim

CUMIS®

Allianz Global Assistance

TO SUBMIT YOUR CLAIM:

STEP 1 Gather all your claim documentation
STEP 2 Complete and sign the claim form
STEP 3 Complete any other necessary forms
STEP 4 Complete the checklist below
STEP 5 Mail all documentation to Allianz Global Assistance

IMPORTANT

- All claims must be reported within 30 days of occurrence.
- Written proof of claim must be submitted within 90 days of occurrence.
- 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.

CHECKLIST

TRIP CANCELLATION (Before departure)
If you had to cancel your trip do you have:

- ❑ The fully completed claim form, signed and dated?
  Incomplete claim forms will be returned to you and this will delay the processing of your claim submission.
- ❑ Your trip itinerary & copy of itemized invoice showing amount paid for your trip?
  For example: e-ticket or paper ticket, hotel, taxes, service fees and any other expenses.
- ❑ Proof of payment for your trip?
  For example: copy of credit and/or debit card statement, cancelled cheques or receipt from travel supplier.
- ❑ Statement from your travel supplier indicating whether a refund and/or credit voucher has been issued or, if no refund and/or credit is available, a copy of the Cancellation Terms and Conditions on the booking(s)?
- ❑ If your trip was cancelled for **medical reasons**, do you have:
  - ❑ The Trip Cancellation & Interruption Insurance Medical Certificate (completed by a physician)?
    Further medical documentation may be required by your Claims Examiner.
  - ❑ Copy of the death certificate (if applicable)?
- ❑ If your trip was cancelled for **non-medical reasons**, do you have:
  - ❑ Supporting documents showing the reason for cancelling your trip?
- ❑ A copy of all documents for your records?

Send your completed forms and original receipts to:

Allianz Global Assistance Claims Department
250 Yonge Street, Suite 2100
Toronto, Ontario M5B 2L7
Canada

To check your claim status, please call:

Toll-free Canada/USA: 1-800-869-6747
Collect worldwide: 416-340-8809
E-mail: claims@allianz-assistance.ca

TRIP INTERRUPTION (After departure) ···›

Trip Interruption

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IMPORTANT

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- Written proof of claim must be submitted within 90 days of occurrence.
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- This form must be completed by the insured or by a parent or legal guardian if the insured is a minor.

CHECKLIST

TRIP INTERRUPTION (After departure)
If you had to interrupt your trip do you have:

- ❑ The fully completed claim form, signed and dated?
  Incomplete claim forms will be returned to you and this will delay the processing of your claim submission.
- ❑ Your **original** trip itinerary (e-ticket or paper ticket) & copy of itemized invoice showing amount originally paid for your trip?
- ❑ Your **new** trip itinerary (e-ticket or paper ticket)& copy of itemized invoice showing amount paid to make changes to your trip?
- ❑ Proof of payment for your trip?
  For example: copy of credit and/or debit card statement, cancelled cheques or receipt from travel supplier.
- ❑ Original receipts for any out-of-pocket expenses?
  For example: hotel, meals, taxi, etc.
- ❑ If your trip was interrupted for **medical reasons**, do you have:
  - ❑ The Trip Cancellation & Interruption Insurance Medical Certificate (completed by a physician)?
    Further medical documentation may be required by your Claims Examiner.
  - ❑ Copy of the death certificate (if applicable)?
- ❑ If your trip was interrupted for **non-medical reasons**, do you have:
  - ❑ Supporting documents showing the reason for the changes to your itinerary?
- ❑ A copy of all documents for your records?

Send your completed forms and original receipts to:

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Trip Cancellation & Interruption

Claim Form

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SECTION 1: PRIVACY AND DECLARATION

Allianz Global Assistance Privacy Statement

Allianz Global Assistance is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

At Allianz Global Assistance, we recognize and respect the importance of privacy. When you enrol for insurance coverage or submit a claim, we establish a confidential file and collect, use and disclose your personal information for the purposes of issuing, administering, adjudicating and/or servicing your insurance. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other persons we have authorized who have a need to know it to perform their duties. Our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security extends to the contracts and agreements we sign with external suppliers and service providers. We may store or process your personal information in Canada, the United States or other countries for processing, storage, analysis or disaster recovery and, under applicable law, governments, courts, law enforcement or regulatory agencies, may, by lawful order, obtain disclosure of your personal information. You can find more details about Allianz Global Assistance's privacy policy at www.allianz-assistance.ca. If you have any questions regarding our privacy practices, please contact the Privacy Officer at :

AZGA Service Canada Inc.
o/a Allianz Global Assistance
250 Yonge Street, Suite 2100
Toronto, Ontario M5B 2L7
Canada

Telephone: 416-340-1980
E-Mail: privacy@allianz-assistance.ca

If you do not agree with our use and disclosure of your information in connection with your application and servicing any policy that we issue, we will not be able to offer you the insurance product you are interested in, service your insurance or adjudicate your claim.

I have read and understood the privacy statement and I consent to the collection, use, retention and disclosure of my personal information or those of my dependants for the purposes stated above. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated.

I hereby assign to AZGA Service Canada Inc. o/a Allianz Global Assistance any benefits obtainable from other sources for losses covered under this policy. I authorize and direct these sources to release payments to Allianz Global Assistance and for Allianz Global Assistance to release pertinent payments to other parties for the purposes of processing my claim.

I certify that the information contained herein is true, complete and accurate and that each of the listed expenses was purchased and/or incurred in connection with the medical treatment of the individual(s) named below. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning this claim, I acknowledge and agree that Allianz Global Assistance may investigate any information about me, my spouse and/or dependents pertaining to this claim, which may be used and disclosed to any relevant Third Party, and where applicable my plan sponsor, for the purpose of investigating and preventing fraud and/or plan abuse.

If I receive payment from Allianz Global Assistance in an amount that exceeds the benefit(s) to which I am entitled under the policy (the "overpayment amount"), then I acknowledge and agree that: (a) I am indebted to Allianz Global Assistance for such overpayment; (b) Allianz Global Assistance has the right to recover the overpayment amount through any means available by law; and (c) Allianz Global Assistance will offset any benefits payable to me by the overpayment amount until Allianz Global Assistance has recovered the overpayment amount in full.

I declare my statements above, including all other past and future statements made through personal or telephone interviews relating to my claim, to be true, complete, current and accurate.

Insured's Signature: _____ Date: MM/DD/YYYY

Insured's Name (please print): _____ Policy #: _____

Trip Cancellation & Interruption

Claim Form

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SECTION 2: INSURED'S INFORMATION

Insured's First Name: Last Name:

❑ Male ❑ Female Date of Birth: MM/DD/YYYY Policy #:

Second Insured's First Name: Last Name:

❑ Male ❑ Female Date of Birth: MM/DD/YYYY Policy #:

Phone #: ( )

Fax #: ( ) Email:

Address: City:

Province: Postal Code: Destination:

Scheduled Departure Date: MM/DD/YYYY Scheduled Return Date: MM/DD/YYYY

SECTION 3: TYPE OF LOSS

Please indicate the general nature of the loss being claimed for: ❑ Trip Cancellation ❑ Interruption ❑ Delays

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

Date symptoms or injury first appeared: MM/DD/YYYY Date you first saw physician for this condition: MM/DD/YYYY

If loss is due to **injury**, please provide details:

Describe how the injury/accident occured:

Date of injury/accident: MM/DD/YYYY

If loss is due to **death**, please provide details:

Date of death: MM/DD/YYYY Cause of death:

Your relationship to sick, injured or deceased person: Name of patient or deceased:

Name and Address of patient's usual Family Physician

Name:

Address:

City: Province: Postal Code:

Name and Address of any other physician who may have treated the patient in the last 12 months

Name:

Address:

City: Province: Postal Code:

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

Date the loss first occured: MM/DD/YYYY Date you cancelled with travel agent/travel supplier: MM/DD/YYYY

SECTION 4: EXPENSES CLAIMED

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

Type of Expense Incurred *(airline ticket, hotel, etc.)*	Date Incurred	Amount Paid	Currency	Amount Reimbursed/Refunded *by Travel Agent or Supplier*
1.	MM/DD/YYYY			
2.	MM/DD/YYYY			
3.	MM/DD/YYYY			
4.	MM/DD/YYYY			

Trip Cancellation & Interruption

Claim Form

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SECTION 5: 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 for credit card

Name: _____

Address: _____

City: _____ Province: _____ Postal Code _____

First 6 digits of credit card #: _____ Expiry Date: MM/YYYY _____

Name of Cardholder (please print): _____ Cardholder Signature: _____

Do you have insurance benefits available through homeowner's insurance, automobile insurance or any other source?

❑ Yes ❑ No If 'Yes', provide details below.

Plan	Name and Address of Insurance Company	Policy #	Telephone
Homeowners Insurance			( )
Tenants Insurance			( )
Travel Insurance other than Allianz Global Assistance			( )
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 explanation: _____

Insured's signature: _____ Date: MM/DD/YYYY _____

SECTION 6: AUTHORIZATION AND CERTIFICATION

I authorize any doctor, hospital or facility providing medical or health-related services, and any other insurer to release and exchange with Allianz Global Assistance or its representatives, any information that is required to process this claim. I assign to Allianz Global Assistance, 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 Allianz Global Assistance. 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 Allianz Global Assistance. 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.

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 _____

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

Signature of Insured (if minor, signature of parent or legal guardian): _____

Signature of policyholder of other insurance in Section 5 (if applicable): _____

Trip Cancellation & Interruption

Medical Certificate

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NOTE: This certificate is to be fully completed and signed by the licensed medical physician who treated the injury/sickness resulting in this claim. Any fee for the completion of this form is the patient's responsibility.

Patient's First Name: Last Name:

❑ Male ❑ Female Date of Birth: MM/DD/YYYY Policy #:

Name of traveller, if different from patient: Relationship to patient:

Diagnosis/condition resulting in claim:

Date symptoms first appeared MM/DD/YYYY Date of first medical consultation: MM/DD/YYYY

Date investigative testing began: MM/DD/YYYY Date condition diagnosed: MM/DD/YYYY

Date patient made you aware of travel plans: 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: City:

Province: Postal Code: Phone: ( )

Has the patient suffered from this medical condition in the past? ❑ Yes ❑ No

If 'Yes', please list below the patient's history of this condition and other related conditions over the 12 months prior to this visit:

Date of Consultation	Symptoms Exhibited/Diagnosis	Treatment Rendered
MM/DD/YYYY		
MM/DD/YYYY		
MM/DD/YYYY		

Please provide a list of the patient's current prescription medications:

Was the condition related to alcohol, misuse of drugs, or self-inflicted injury? ❑ Yes ❑ No

If 'Yes', please provide details:

Was the patient hospitalized? ❑ Yes ❑ No Admission Date: MM/DD/YYYY Discharge Date: MM/DD/YYYY

Name of Hospital:

Was the visit related to pregnancy? ❑ Yes ❑ No Date of last Menstrual Period: MM/DD/YYYY Expected Delivery Date: MM/DD/YYYY

If 'Yes', please provide specific details:

Please provide the name and phone number of any other physicians who treated the patient, or referred the patient to you:

Address: City:

Province: Postal Code: Phone: ( )

Date the patient was assessed as unfit to travel: MM/DD/YYYY Date you advised traveller not to travel: MM/DD/YYYY

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.

Physician's Signature:

Physician's Name (please print):

Date: MM/DD/YYYY Email:

Street Address:

City/Town: Postal Code:

Telephone: ( ) Fax: ( )

PHYSICIAN'S STAMP HERE