TRIP CANCELLATION / TRIP INTERRUPTION / TRIP DELAY CLAIM FORM

Trip Cancellation (prior to departure), Interruption (Return early) or Delay (beyond scheduled return date)

CLAIM MUST BE FILED WITHIN 90 DAYS OF INCIDENT.

Along with your completed and signed claim form, please provide the following documentation. Failure to provide the documentation requested will result in a delay of our claims adjudication.

- ☐ If your insurance is through your credit card provider, please provide a copy of your monthly billing statement, confirming the payment of your trip. Please ensure that the last four digits of your credit card number are visible for verification of coverage.
- ☐ A copy of your complete travel itinerary which includes passenger names, dates of travel and trip amounts.
- ☐ Documentation confirming any refunds from any other insurance/travel supplier or airline that you have received.
- ☐ A copy of all invoices for any additional pre-paid trip arrangements, such as hotels, cruise, car rentals.
- ☐ If you are claiming for trip cancellation due to a medical reason please have the primary care physician of the patient complete section four of the claim form or provide a copy of the death certificate, if applicable.
- ☐ If you are claiming for trip interruption or delay due to a medical emergency please have the physician who recommended your interruption or delay complete section four of the claim form or provide a copy of the death certificate, if applicable.
- ☐ If the reason for your cancellation/interruption/delay is non-medical, please provide documentation to confirm the reason for the claim such as a subpoena to appear in court, your record of employment, a copy of travel advisory.

FREQUENTLY ASKED QUESTIONS:

1. Why is my doctor required to provide information and sign a section of this claim form? (Trip Cancellation)

A medical doctor must recommend you cancel your trip. You will need to have the attending physician complete the medical section of the claim form or submit a letter containing all pertinent information, to validate your claim.

E-mail: submit@allianz-assistance.ca

How can we help?

Allianz Global Assistance
4273 King St. E.
Kitchener, ON
N2P 2E9 Canada
Website www.allianz-assistance.ca

Legal Entities:
AZGA Service Canada Inc.
AZGA Insurance Agency Canada Ltd.

2. Why do I need a note from a doctor at my destination? (Trip Interruption / Trip Delay)

If a medical situation requires that you interrupt or delay the return from your trip, you will need to have the attending physician at your destination submit a letter containing all pertinent information, to validate your claim. The letter must contain the following:

- Diagnosis
- Date(s) of doctor's visit or hospitalization
- Reason for interruption or delay

3. What do the terms "Non-transferable" and "Non-refundable" mean?

A non-transferable ticket cannot be used by any person other than the named passenger on the ticket. It may however be possible to change the travel dates on a non-transferrable ticket. A non-refundable ticket cannot be returned for a refund but it may be possible to change the travel dates. Refer to your booking or travel agent to confirm the specific details of your ticket.

Return Claim Form and Documents to:
submit@allianz-assistance.ca

Allianz Global Assistance
P.O. Box 277
Waterloo, ON
N2J 4A4
Fax: 519-742-9471

TRIP CANCELLATION/INTERRUPTION/DELAY CLAIM FORM

(Check one) I am claiming for: ☐ **Trip Cancellation** ☐ **Trip Interruption** ☐ **Trip Delay**

Please print unless otherwise indicated

SECTION 1: ACCOUNT INFORMATION

Case # (if applicable): _____

Name: _____ Date of Birth (MM/DD/YY): _____

Street: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Business Phone :( )_____

E-mail: _____

Policy Number _____ (if credit card number please only list last four digits)

Name as it appears on this card _____Date of Birth of this card holder (MM/DD/YY): _____

Issuing Bank: _____

Which card was the purchase made on? ☐ Primary Card ☐ Secondary Card, if you are the secondary please provide the Primary Cardholders: Name: _____ Date of Birth: _____

Address (if different): _____

SECTION 2: TRAVEL DETAILS

Original Planned Departure Date: _____ (MM/DD/YY) Original Planned Return Date: _____ (MM/DD/YY)

Actual Return Date: _____ (MM/DD/YY)

Nature of Travel: ☐ Business ☐ Leisure ☐ Other Mode of Travel: ☐ Car ☐ Airplane ☐ Other

Date of Initial trip deposit: _____ (MM/DD/YY) Date of final payment: _____ (MM/DD/YY)

Date of Incident (Cancellation/Interruption/Delay): _____ (MM/DD/YY)

Describe in detail the cause and circumstances related to this claim: _____

_____

_____

SECTION 3: CLAIM SUMMARY

Total number of claimants: _____ Relationship to policyholder: _____

	Amount	Currency	
Transportation Expenses including taxes (air fare etc.)	_____	_____	Attach proof of payment and non-refundable amounts, along with documentation stating cancellation or interruption penalties.
Accommodation and meal Expenses (receipts required)	_____	_____	
Other Expenses	_____	_____	
	_____	_____	
Total Expenses Paid	_____	_____	
Total Refund	_____	_____	Refund from travel agent/airline/other
Amount of Claim	_____	_____	Total expenses less refund amount

Please have this section completed by a physician:

SECTION 4: MEDICAL INFORMATION

Patient's Name: _____ Patients Relationship to Insured: _____

Patient's Date of Birth: (MM/DD/YY):_____ (If the patient is an insured person under this plan)

Medical reason for claim: _____Date Symptoms first noted (MM/DD/YY):_____

Is this a new condition? ☐ Yes ☐ No If No, what date was this condition first diagnosed (MM/DD/YY): _____

Date of first doctor visit for present onset (MM/DD/YY): _____

Has the patient received treatment or advice for this condition in the past year? ☐ Yes ☐ No

If YES, please provide all dates (MM/DD/YY):

_____

Does the patient take ongoing medication for this condition? ☐ Yes ☐ No

If YES, please provide names: _____

When was the medication last altered? (MM/DD/YY) _____ Why? _____

If patient was referred to you, provide name and phone number of referring physician:

_____ Date of referral (MM/DD/YY)

_____

Were any follow up treatments required? ☐ Yes ☐ No If YES, please specify dates (MM/DD/YY): _____

Was the patient hospitalized? ☐ Yes ☐ No If YES, from (MM/DD/YY) _____ to _____

Name of hospital: _____

If condition was due to pregnancy, please provide:

Date of confirmation of pregnancy: (MM/DD/YY) _____ Expected date of delivery: (MM/DD/YY) _____

Is the Patient a traveller? ☐ Yes ☐ No. If yes, did you advise the patient to cancel his/her travel plans? ☐ Yes ☐ No

Date advised not to Travel? (MM/DD/YY) _____

Patient was not fit to travel from (MM/DD/YY) _____ to _____

Certification

Your certification will establish the validity of the claim. Please complete fully.

According to my records, the above information is true and correct. I also agree that I may be contacted for additional information regarding the above patient, including sending copies of medical records if needed.

Name of the attending physician: _____

Address: _____

City: _____ Province/State: _____ Country: _____

Postal Code/Zip Code: _____ Telephone: _____

Signature of Attending Physician: _____ Date: _____

If different from above: Name of Family Physician: _____ Telephone: _____

Address: _____

SECTION 5: OTHER INSURANCE COVERAGE

Please indicate all insurance coverage you (or the patient) may have through any other insurer, including employer group benefits, union or pensioner plans or other travel insurance policies. Attach an additional page if required.

1) Name of Insurer: _____ Phone:_____

Address_____

Lifetime limit on policy? ☐ No ☐ Yes (specify) $_____ Policy #_____Certificate #_____

Name of Policyholder: _____ Signature of Policyholder: _____

2) Name of Insurer: _____ Phone:_____

Address_____

Lifetime limit on policy? ☐ No ☐ Yes (specify) $_____ Policy #_____Certificate #_____

Name of Policyholder: _____ Signature of Policyholder: _____

Have these bills been filed with any other company? ☐ No ☐ Yes (specify)

_____

_____

SECTION 6: IMPORTANT, PLEASE READ AND SIGN

CERTIFICATION: The undersigned hereby certifies that the information provided by him or her on this form and otherwise in support of this claim is complete and accurate to the best of each of his or her knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be void, payment of this claim denied and any claim payments made in error recovered. The undersigned agrees to refund the amount of any payments that should not have been made.

PERSONAL INFORMATION NOTICE: The information provided with respect to this claim is required by the insurer and its authorized administrator, Allianz Global Assistance, and any insurance adjuster appointed to investigate any losses on its behalf (collectively "we" "us" "our") for insurance purposes, such as to assess any entitlement to benefits and to administer this claim. We will investigate and administer this claim by consulting the insurer's existing files and by exchanging additional information[1] with the undersigned and third parties, such as law enforcement, fire and emergency services departments, parties involved with any subrogation action, and other independent sources. **ALL REQUIRED INSURANCE, POLICE, CLAIM FORMS AND REPORTS MUST BE PROVIDED TO US BEFORE YOUR CLAIM CAN BE PROCESSED**.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize any physician, hospital or other medical provider who has attended or examined me to release to and exchange with Allianz Global Assistance or its representatives any and all information[1] regarding my medical history, symptoms, treatment, examination or diagnoses for the purpose of adjudicating my claim.

Primary Cardholder/Subscriber (please print) _____

Signature of Primary Cardholder/Subscriber: _____ Date signed: _____
(MM/DD/YY)

Patient Signature: _____ Date signed: _____
(MM/DD/YY)

CLAIM MUST BE FILED WITHIN 90 DAYS OF INCIDENT.

Completed and signed claim forms and supporting documents should be returned to Allianz Global Assistance within 90 days from the date of incident. Prompt attention to this request for information is required to adjudicate your claim.

Please note that photocopies and scanned images are acceptable. However, it is your responsibility to keep the originals for one year after payment as we reserve the right to audit and ask for the originals to be sent to us during that time.

Should you choose to submit original documents they will not be returned upon completion of your claim.

[1] IMPORTANT: Personal information excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.