CLAIM AND AUTHORIZATION FORM **CLAIM # ______________**

CUSTOMER INFORMATION

Full Last Name: ______ First Name: ______ Date of Birth: ______

Address: ______ Apt. #: ______

City: ______ Province: ______ Postal Code: ______

Telephone: Home: ______ Business: Policy #:

Amount Claimed: ______ Currency: ______

CLAIM AND TRIP INFORMATION

Departure Date: ______ Return Date: ______ Date of Occurrence: ______

Patient's Name: ______ Patient's Relationship to Insured: ______

Location of Occurrence: (City/Town): ______ Country: ______

Name of your Canadian Physician(s): ______

Address: ______ Tel: ( ) ______ Fax: ( ) ______

City: ______ Country: ______ Postal Code: ______

TRIP CANCELLATION/TRIP INTERRUPTION

Describe the circumstances which resulted in the cancellation/interruption of your trip: ______

If you cancelled/interrupted your trip due to the illness/death of a family member, please state your relationship to the ill/deceased family member:

______

Date of the cause of cancellation: M ______ D ______ Y ______ Date travel agent/airline notified: M ______ D ______ Y ______

AUTHORIZATION TO PHYSICIANS, HOSPITALS AND OTHER MEDICAL PROVIDERS AND SPECIAL AUTHORIZATION AND DIRECTION

1. I authorize you to give RBC Insurance Company of Canada any and all information you have regarding me, while under observation or treatment by you, including my medical history, diagnoses and test results, and I hereby consent to the disclosure of such information by RBC Insurance Company of Canada to other sources as may be required for the processing of my claim for benefits obtainable from other sources.

2. I hereby assign to RBC Insurance Company of Canada any benefits obtainable from other sources for losses covered under this policy. I also direct these sources to forward payment to RBC Insurance Company of Canada for my claim submitted by RBC Insurance Company of Canada with regard to these losses. A photocopy or faxed copy of this authorization is acceptable.

3. I understand my claim may be subject to review and investigation and I give RBC Insurance Company of Canada or their authorized agents authority to acquire any documents or statements from other insurers, financial institutions, travel suppliers, any company or public/private organization which can provide information related to my claim, and I hereby consent to the disclosure of such information by RBC Insurance Company of Canada to other sources as may be required for the processing of my claim.

Claimant's/Patient's Name: ______ Date: ______

(Please Print)

I authorize RBC Insurance Company of Canada to direct payment to: ______ who has pre-paid my expense(s).

Claimant's/Patient's Signature: ______ Date: ______

(if Patient is not a minor, Patient must sign this section)

OTHER INSURANCE INFORMATION

(This section must be completed by the insured person. If the insured is a minor, the parent/legal guardian must complete this section)

Do you have group benefits through (check all that apply and provide details):

☐ Your Employer ☐ Your Spouse's Employer ☐ A Retiree Plan

Name of Plan Member/Employee/Retiree: ______ Date of Birth: M ______ D ______ Y ______ Policy/Plan #: ______

Name of Employer/Group: ______ ID #(Employee #, Certificate #, etc.): ______

Name & Address of Insurance Company: ______

Name of Spouse: ______ Date of Birth: M ______ D ______ Y ______ Policy/Plan #: ______

Name of Employer/Group: ______ ID #(Employee #, Certificate #, etc.): ______

Name & Address of Insurance Company: ______

Do you have benefits available through any other Travel Insurance Company or Travel Supplier? ☐ Yes ☐ No

If yes, Name & Address: ______

Do you have benefits available through (check all that apply): ☐ Home Insurance? ☐ Auto Insurance? ☐ Other? ______

Policy #: ______ Name & Address of Insurance Company: ______

______

Do you have a Bank Credit Card? (some credit cards have travel benefits) ☐ Yes ☐ No

If yes, please provide the card # ______ Name of Financial Institution: ______

Is there a co-applicant? ☐ Yes ☐ No If yes, Name : ______

☐ I hereby warrant that I do not have any other travel or out-of-province medical insurance coverage.

Claimant's Signature: ______ Date: ______

MEDICAL CERTIFICATE

Patient's Name: ____________________

Relationship to Insured: ____________________

Patient's Address: ____________________

____

Insured's Name: ____________________

Scheduled Departure Date: ____________________

Amount of Claim $ ____________________

ATTENDING PHYSICIANS CERTIFICATE

(To be completed in full by the attending physician for all clinic, office, out-patient and short duration emergency room visits.)

Doctor: your certificate will establish the validity of the claim. Please complete fully. Applicable to the person whose condition was the cause of this claim.

Diagnosis related to Claim: 1. ____________________ Date: M _____ D _____ Y_____

(List this in order of severity) 2. ____________________ Date: M _____ D _____ Y_____

3. ____________________ Date: M _____ D _____ Y_____

1. Is this a new condition ☐ Yes ☐ No If "No", on what date was this condition first diagnosed? .... Date: M _____ D _____ Y_____
2. Date of first consultation for present onset: .... Date: M _____ D _____ Y_____
3. Has the patient received treatment or advice for this condition in the last year? ☐ No ☐ Yes

   If "Yes", please provide all dates: ____________________
4. Does the patient take ongoing medication for this condition? ☐ No ☐ Yes

   If "Yes", please provide Names: ____________________
5. When was the medication last altered? .... Date: M _____ D _____ Y_____

   Why? ____________________
6. Date medication first prescribed? .... Date: M _____ D _____ Y_____
7. If patient was referred to you, provide name and phone number of referring physician: ____________________

   ____
8. a) Did patient make you aware of travel plans ☐ No ☐ Yes if "Yes", Please specify When: .... Date: M _____ D _____ Y_____

   b) Did patient receive medical approval from you for the trip? ☐ No ☐ Yes
9. a) If condition was due to pregnancy, what was the expected date of delivery? .... Date: M _____ D _____ Y_____

   b) If condition was due to an accident, what was the date of occurrence? .... Date: M _____ D _____ Y_____
10. Were follow up treatments required? ☐ No ☐ Yes Please specify dates: ____________________
11. Was the patient hospitalized? ☐ No ☐ Yes From ____________ to ____________

    Name of the Hospital: ____________________
12. a) In your professional opinion, from what date did this condition preclude travel for the patient or a family member? Date: M _____ D _____ Y_____

    b) On what date was the patient or family member advised to cancel the trip? .... Date: M _____ D _____ Y_____

    c) On what date was his condition stable enough to permit travel? .... Date: M _____ D _____ Y_____

Comments: ____________________

____

Name of the Attending Physician (print): ____________________

Signature of Attending Physician: ____________________ Date (MM/DD/YY) ____________

Address: ____________________

City: ____________ Province: ____________ Country: ____________

Postal Code: ____________________ Telephone: ____________

ATTENDING PHYSICIAN'S STAMP OR ATTACH LETTERHEAD OR PRESCRIPTION PAD

The insured is responsible for any fees charged for the completion of this medical certificate.