CLAIM AND AUTHORIZATION FORM

CLAIMANT INFORMATION - TRIP CANCELLATION

Last Name:	First Name:	Date of Birth:
Address:		
City:	Province:	Postal Code:
Home Phone:	Mobile Phone:	
Email Address:		

'*You*' or '*Your*' refers to the primary insured named on this claim form. If the Primary insured is a minor, the parent or legal guardian is referred to as '*You*' or '*Your*'

Please select your preferred method of contact: Email ☐ Home Phone ☐ Mobile Phone ☐

If you selected 'Home Phone' or 'Mobile Phone'; please advise the best time/day to be reached between Monday – Friday 8AM – 5PM EST

Enter Time: Prefered day: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

(by selecting your preferred method of contact, you are providing consent for RBC Insurance Company of Canada to discuss your claim information via phone or email)

LIST OF INSURED CLAIMANTS

Full Name	Date of Birth (mm-dd-yy)	Relationship to Insured	If a dependent child, is he/she a full time student?

CANADIAN FAMILY DOCTOR AND/OR SPECIALIST INFORMATION

Your medical history may be required to fully review your claim. Please provide your Canadian Physician(S) information below

Family Physician(s):	Telephone:
Walk-in Clinic (if applicable):	Telephone:
Canadian Specialist(s):	Telephone:

CLAIM DETAILS

1. Trip Departure Date: Trip Return Date:

2. Date you were aware you had to cancel your trip:

3. Date you cancelled your trip:

4.What symptoms did you have or what was the diagnoses given by the attending doctor?

5. If you incurred eligible expenses and your claim is payable, should the cheque be made out in your name?

◯ YES - The Claim will be paid out to me

◯ NO - Please provide name and address of whom the claim should be paid out to:

Name:	
Address:	

6. Was the trip purchased with a Credit Card? ◯YES ◯NO

If YES, please provide details below;

To help you receive all additional payments you are entitled to, we will coordinate with any other potential Insurers on your behalf. We will determine if the card provides coverage for your incident.

Credit Card Number:		Type of Credit Card:	

CLAIM AND REFUND INFORMATION

Description	Original Amount Paid	Amount Refunded to You	Refunded From	Remaining (Amount Claimed)

* If your amounts are in more than one currency, please total each separately

Total Amount: _____ Currency: _____

Total Amount: _____ Currency: _____

AUTHORIZATION - TRIP CANCELLATION

The following authorization wording is providing RBC Insurance Company of Canada authorization to obtain, recover and forward information, payments and/or obtain recovery from your Credit Card, Extended Health benefits company, Airlines and/or other sources on your behalf.

1. I hereby assign, to RBC Insurance Company of Canada, any claim or right of action I may have against any person, company or organization for the loss or expense that has been paid to me by RBC Insurance Company of Canada. This assignment includes but is not limited to any rights I may have for any full or partial refund, credit or other benefit that may be available to me from any person, company or organization including but not limited to any airline, travel provider, tour operator, travel company and/or credit card company. I further agree to cooperate with RBC Insurance Company of Canada in its efforts to enforce my rights as against any other party and agree that RBC Insurance Company of Canada may, in relation to the rights I am assigning to them, commence a legal action in my name as against any other party at its own expense. If I recover against any third party, I agree to hold in trust sufficient funds to reimburse RBC Insurance Company of Canada for the amount of the loss or expense it paid to me. I hereby direct that any payment from any person, company or organization in relation to any claim, right of action, refund, credit or other benefit which I have hereby assigned, shall be made payable to RBC Insurance Company of Canada. A copy of this assignment and direction shall have the same authority as the original.

2. 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.

3. 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.

_____

Print Name of Claimant/Designated Legal Representative

Signature of Claimant/Designated Legal Representative ***Date***

If claimant is a minor the Parent or Legal Guardian must sign this section on his/her behalf. If a legal representative, other than the patient's legal guardian signs this form, proof of "Legal Representative status" is required i.e. (Power of Attorney, Will, etc.). A copy of this authorization shall have the same authority as the original.

MEDICAL CERTIFICATE

Patient's Name:

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

Claim/Policy number:

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

1. Diagnosis / medical reason causing trip cancellation or interruption:

2. On what date did the patient first present to you or any other physician for symptoms of this condition? (physical or clinical)

If seen in follow up, please provide and attach clinical notes for all follow up dates entered below:

Follow up dates MM/DD/YY:	1.
	2.
	3.
	4.

3. If known, date diagnosis determined?

4. Does the patient take prescribed medication for this condition? ◯ Yes ◯ No

If yes, please provide details (if necessary attach list):

Name of drug	Date First Prescribed	Date Altered

5. If condition is pregnancy complications, what was the expected date of delivery?

*Additional Comments or notes:

Signature of attending Phyisican: Date:

Address:

City: Province: Country:

Postal Code: Telephone: Fax:

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. For any inquiries, please call our Claims Customer Service Department at 1-800-263-8944.