CLAIM AND AUTHORIZATION FORM

CLAIMANT INFORMATION – TRIP CANCELLATION

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

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Day Time Phone: _____

E-mail Address: _____

CLAIM AND TRIP INFORMATION

Departure Date: _____ Return Date: _____

Diagnosis: _____

Describe the circumstances which resulted in the cancellation of your trip: _____

_____

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

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: _____

To help you receive all payments you are entitled to, we will coordinate with any other potential Insurers on your behalf. If your trip was purchased on a credit card, please provide the credit card number and a copy of your statement. We will determine if the card provides coverage for your incident.

Credit Card Number: _____

Type of Credit Card: _____

LIST OF SUBMITTED EXPENSES

Description of your Out-of-Pocket Expenses	Amount	Currency	Original Supporting Documentation Enclosed Y/N

*** Please attach another sheet if your expenses exceed the space provided**
*** If your expenses are in more than one currency, please total each separately**

Total Amount: _____ **Currency:**_____

Total Amount: _____ **Currency:**_____

Payment Direction (all payments are made by cheque in Canadian Funds)

Although I am the insured person on this policy, I authorize RBC Insurance Company of Canada to pay the benefits under this claim to the following person:

(I understand that if this section is not completed, I will receive the amount payable)

Name: _____

Address: _____

Please complete both sides of the form

AUTHORIZATION – TRIP CANCELLATION

1. 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.

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.

4. I hereby consent the disclosure of my claim information to the following people listed: (please specify relationship)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____

Print Name of Claimant/Designated Legal Representative

_____ _____

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

A copy of this authorization shall have the same authority as the original.

Please complete both sides of the form

MEDICAL CERTIFICATE

CLAIM#:

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.