

CLAIM AND AUTHORIZATION FORM

CLAIMANT INFORMATION – TRIP INTERRUPTION

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 interruption of your trip: _____

Date of the cause of interruption: 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: _____

LIST OF SUBMITTED EXPENSES

| Description of your Out-of-Pocket Expenses | Date Incurred | Amount | Currency | Original Receipts 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: _____

OTHER INSURANCE INFORMATION – TRIP INTERRUPTION

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

Other than your coverage with us, do you, your spouse or your parents (if you are a dependent) have any other insurance coverage?

1. Other Travel Plans YES NO - if YES, please complete **Section 1** below
2. Credit Cards (that were used to purchase your trip) YES NO - if YES, please complete **Section 2** below

Section 1 – To help you receive all payments you are entitled to, we will co-ordinate with any other insurers on your behalf

Name of Policyholder: _____

Name of Insurance Company: _____

Policy number: _____

Section 2 – To help you receive all payments you are entitled to, we will co-ordinate with any other insurers or Credit Card coverage that may provide similar benefits on your behalf.

Name of Cardholder: _____ Relationship to Cardholder: _____

Type of credit card: _____

Credit card number: _____

AUTHORIZATION

- 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.
- 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.
- 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.
- I hereby consent to the disclosure so such 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.

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.