Re: Baggage Loss, Damage & Delay Insurance Claim

We are sorry to learn that you had experienced issues with your baggage as a result of your trip. The Manufacturers Life Insurance Company (Manulife Financial) has appointed Active Care Management as the provider of all assistance and claims services under this policy.

The claimant is responsible for completing and/or producing any documentation required to enable us to process and confirm the eligibility of the claim. If the claimant is a minor, then the legal guardian must sign on the claimant's behalf.

To process your claim, written proof must be submitted **within ninety (90) days** of the occurrence. The following items are required to be completed in full and returned to ACM to process your claim:

- The enclosed Baggage Loss, Damage & Delay Insurance Claim Form
- Copies of reports from the authorities as proof of loss, damage or delay
- Proof of length of duration delayed and time of baggage return if claim is due to delay.
- Proof that you owned the articles and original itemized bills and receipts for their replacement. Please be sure to keep a copy for your records as the originals will not be returned to you.

Failure to provide accurate information and fully completed forms may invalidate or delay claim processing. We reserve the right to request additional information as required.

Sign and mail all forms, along with all applicable documents noted above, to:

Active Care Management
P.O. Box 1237
Station A
Windsor ON, N9A 6P8

Should you have any further questions regarding the claim, please contact us at Active Care Management at 1 877-292-0082 toll free.

ACM
ACTIVE CARE MANAGEMENT

BAGGAGE LOSS, DAMAGE & DELAY INSURANCE CLAIM FORM

SECTION A – CLAIMANT INFORMATION

Insured's Name (Last Name, First Name, Middle Initial)			
Policy Number	Date of Birth MM | DD | YYYY	Gender ☐ Male ☐ Female	
Home Address	City	Province	Postal Code
Email Address	Phone ( )	Fax ( )	
Travel Destination	Date Trip Booked MM | DD | YYYY	Departure Date MM | DD | YYYY	Return Date MM | DD | YYYY

SECTION B – LOSS INFORMATION

Type of Loss: ☐ Lost ☐ Damage ☐ Theft ☐ Delay	Date of Loss MM | DD | YYYY	Date Loss Reported MM | DD | YYYY

Describe how and where the loss occurred:

To whom was loss reported? ☐ Airline ☐ Cruise Line ☐ Bus Line ☐ Tour Guide ☐ Hotel ☐ Police

☐ Other - please specify: _____

☐ Not reported - please explain:

SECTION C – SCHEDULE OF ITEMS LIST, DAMAGED, STOLEN OR DELAYED

Item Description	Quantity	Owner of Item	Date Purchased	Purchase Price (CDN Funds)	Estimated Repair Cost Or Actual Cash Value
			MM | DD | YYYY		
			MM | DD | YYYY		
			MM | DD | YYYY		
			MM | DD | YYYY		
			MM | DD | YYYY		
			MM | DD | YYYY		
			MM | DD | YYYY		

Attach a separate sheet if necessary.

SECTION D – OTHER INSURANCE COVERAGE (If the insured is a minor, this is applicable to parent or legal guardian)

Plan	Name of Insurance Company	Policy #	Phone #
Homeowners Insurance			
Tenants Insurance			
Other Travel Insurance			
Other:			

Have you claimed from any other insurer? ☐ Yes – attach a copy of the settlement or denial ☐ No – explain why:

Credit Card Coverage

Were any items in Section C paid by credit card? ☐ Yes ☐ No		Name of Issuing Bank for Credit Card:	
Address	City	Province	Postal Code
Name of Cardholder	First 6 credit card numbers	Date of Expiry MM | DD | YYYY	
Signature of Cardholder *(if different from insured)*		Date Signed MM | DD | YYYY	

SECTION E – AUTHORIZATION

I authorize any other insurer to release and exchange with ACM or its representatives any information that the insurer requires to process this claim. I assign to ACM any benefits payable from any other sources for losses covered under this policy and I authorize and direct such payers to forward payment directly to ACM. I also authorize any third party providing me with assistance in this claims process, to have access to any and all relevant claims information related to the adjudication of my claim with ACM. I confirm I am authorized to act on behalf of my dependants for these purposes. A photocopy of this authorization shall be as valid as the original. I certify that the information provided in connection with this claim is complete, true and accurate.

If you authorize payment of this claim to anyone other than yourself or your provider, please provide name of recipient:

Name of Insured (Last Name, First Name, Middle Initial)	Date MM | DD | YYYY
Insured's Signature (If minor, signature of parent or legal guardian)	Date MM | DD | YYYY
Signature of policy holder of other insurance stated in Section D (if applicable)	Date MM | DD | YYYY

ACM is committed to protecting the privacy, confidentiality and security of the personal information we collect, use and disclose. Your personal information will be used only for the purpose of providing you with the requested insurance services. For a copy of ACM's privacy policy, please contact us.