Re: Trip Cancellation, Interruption and Delay Insurance Claim

You are required to notify Active Care Management prior to Treatment. Your policy may limit benefits should You not contact the assistance company within a specific time period.

Active Care Management is the company responsible for managing your claim. In order for us to process your claim as quickly as possible, please follow the instructions below.

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. If this claim involves illness, injury or death, Section C - Physician's Statement must be completed by your physician. A doctor's note is not sufficient documentation to process your claim.

Failure to provide accurate information and fully completed forms may invalidate or delay claim processing. In order to expedite the claim, please return the original completed forms and all supporting documentation as soon as possible and keep a copy for your records. 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 toll-free at 1 877-292-0082 or collect to Canada 1-519-251-7834.

Sincerely,
Active Care Management

Encls.

TRIP CANCELLATION, TRIP INTERRUPTION & TRAVEL DELAY 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 ( )

SECTION B – TRAVEL INFORMATION			
Travel Destination	Date Trip Booked MM | DD | YYYY	Departure Date MM | DD | YYYY	Return Date MM | DD | YYYY
Travel Agency Name	Phone ( )		Fax ( )
Agency Address	City	Province	Postal Code
Travel Agent Name	Email Address	Reservation #	Trip Cost (CDN Funds)
Reason for trip cancellation, trip interruption or travel delay			Date of Incident MM | DD | YYYY
To whom did you notify?			Date of Notification MM | DD | YYYY

Schedule of Non-Refundable Travel Arrangements

Supplier Name / Description	Amount Paid	Amount Refunded to you	Refunded By	Amount Claimed

SECTION C – PHYSICIAN'S STATEMENT (To be completed by physician only. Only required if this claim involves illness, injury or death. If related to death, only complete applicable fields.)

Patient's Last Name	Patient's First Name	Date of Birth MM | DD | YYYY

Attending Physician Name (Last, First, Middle)

Physician Address	City	Province	Postal Code

Email address	Phone ( )	Fax ( )

This treatment is the result of: ☐ Injury ☐ Sickness	Diagnosis

Date of first consultation: MM | DD | YYYY	Date symptoms/injury first occurred: MM | DD | YYYY	ICD Code

List all dates of examination/treatment for this condition from initial consult to present:	Date patient became medically unable to travel: MM | DD | YYYY
Has this patient ever been treated for this or a related condition? ☐ Yes ☐ No If 'Yes" list dates of treatment and diagnosis:	Expected date patient able to travel: MM | DD | YYYY

Is this condition a complication of an underlying condition? ☐ Yes ☐ No
If 'Yes" please specify:

Was patient referred to you by another physician? ☐ Yes ☐ No	Physician Name

Physician Address	City	Province	Postal Code

Injury

Is this claim the result of an injury? ☐ Yes ☐ No - *If 'No', proceed to Illness Section*	Date of Injury MM | DD | YYYY

Brief Description of accident or injury (time, location, how it occurred):

Does this claim relate to a motor vehicle accident? ☐ Yes ☐ No - *If 'No', proceed to Illness Section*

How and where did accident occur?

Name of Motor Vehicle Insurance Company	Policy#	Phone ( )

Address	City	Province	Postal Code

Illness		
Date symptoms first appeared MM | DD | YYYY	First date of treatment MM | DD | YYYY	Describe Illness

Had the patient ever experienced this illness or a similar problem before? ☐ Yes ☐ No	Date of Previous Occurrence MM | DD | YYYY
Treating Doctor's Name	Phone ( )
Describe Conditions / Diagnosis	

Medical Facilities – list facility where treated and doctors consulted

Name	Address	Phone	Fax	Date
				MM | DD | YYYY
				MM | DD | YYYY
				MM | DD | YYYY
				MM | DD | YYYY

Physician's Authorization and Certification

I certify that the information provided in this section is complete, true and accurate to the best of my knowledge and belief.	Physician's Stamp
Physician's Signature	
Date MM | DD | YYYY	

SECTION D – AUTHORIZATION

I authorize any doctor, hospital or facility providing medical or health-related services, and any other insurer to release and exchange with ACM or its representative, any information that is required 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 payors 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 Patient/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

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.