

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: _____

AUTHORIZATION – TRIP CANCELLATION

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.
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

If patient 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.

Please send the required forms and documents to the following mailing address:

RBC Insurance of Canada
P.O. Box 97
Station A,
Mississauga, ON, L5A2Y9

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.