RBC Insurance Company of Canada
P.O. Box 97 Station A
Mississauga, ON L5A 2Y9
Telephone: 905-816-2562
1-800-222-9978
Fax: 905-813-4719
1-888-298-6340
Rbcroyalbank.com/travel-insurance

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

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 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.