Trip Cancellation / Trip Interruption / Trip Delay Claim Form

SUBMIT CLAIM TO: **AIR MILES® TRAVEL INSURANCE**
c/o Pottruff Smith Travel Insurance Brokers Inc.
8001 Weston Road, Suite 300, Woodbridge, Ontario, L4L 9C8
Telephone: 1-866-298-6581 Fax: 905-856-1539

IN QUEBEC: **Assurance voyage AIR MILES^md**
a/s Pottruff & Smith Courtiers d'Assurance Voyage Inc.
83, rue Turgeon, Bureau 300, Ste-Thérèse, Québec, J7E 3H7
Téléphone : 1-866-298-6581 Téléc. : 450-434-5543

UNDERWRITTEN BY: **Reliable Life Insurance Company & Old Republic Insurance Company of Canada (Hamilton, Ontario)**

CLAIMS WILL NOT BE PROCESSED UNTIL THE REQUIRED SECTIONS HAVE BEEN FULLY COMPLETED AND SUBMITTED WITH ALL OF THE REQUIRED DOCUMENTATION

Please remember to complete both sides and all applicable sections of this form and submit with the original receipts for any out-of pocket expenses incurred. **Incorrect or incomplete claim forms will delay settlement of the claim.**

For claims related to Travel Accident, Baggage, Personal Money and Rental Vehicle Physical Damage please download the forms from www.airmiles.ca or contact AIR MILES Travel Insurance at 1-866-298-6581.

Claimant Information and Explanation of Loss THIS SECTION TO BE COMPLETED IN FULL BY ALL CLAIMANTS

CLAIMANT 1 Mr/Mrs/ Miss/Ms	Insured Last Name	First Name	Birth Date D M Y	AIR MILES	Amount Claimed/ Currency	Policy/Confirmation Number
CLAIMANT 2 Mr/Mrs/ Miss/Ms	Insured Last Name	First Name	Birth Date D M Y	AIR MILES	Amount Claimed/ Currency	Policy/Confirmation Number

Address for Correspondence or Claim Payments No./Street/Apt. | City

Province | Postal Code | Home Telephone No. | Business Telephone No.

Scheduled Date of Departure D M Y | Departure Point | Destination | Scheduled Date of Return D M Y | Date of Cause of Claim D M Y

Name of person who completed this form | Relationship to claimant | Date Claim Submitted D M Y

Describe in detail the cause and circumstances of the trip cancellation or trip interruption or trip delay

Did you receive any refunds from any other source? Yes ◯ No ◯ | Amount Received/Currency

On what date was the trip booked through the AIR MILES Reward Program? D M Y | Date of Departure D M Y | Name of the AIR MILES Travel Specialist who cancelled your trip

On what date was the trip cancelled through the AIR MILES Reward Program? D M Y | Date of Return D M Y | Telephone No.

Is this claim due to the sickness, injury or death of a person other than the claimant? No ◯ Yes ◯ **If yes, please answer the following:**

Name of Sick/Injured/Deceased Person*
* The Physician's statement must be completed by the attending Physician of the Sick/Injured/Deceased Person | Relationship to the Claimant

Address of Sick/Injured/Deceased Person **(if other than the claimant)** No./Street/Suite No.

City | Province | Postal Code | Telephone No.

Physician's Statement for trip cancellation or trip interruption claims. If your claim is due to sickness, injury or death you must have this section completed by the attending physician of the person whose medical condition or medical problem was the cause of the cancellation or interruption

Patient's Name | Date of Birth D M Y

1. Primary Diagnosis (Condition which is the cause of the claim)

2. Is this a new condition? No ◯ Yes ◯ | If no, when was this condition first diagnosed? D M Y

3. Date of consultation for the current onset of this condition? D M Y

4. Has the patient received treatment or advice for this condition (or related condition) in the past year? Yes ◯ No ◯
   If yes, please provide all dates: D M Y | D M Y; D M Y | D M Y

5. Is the patient prescribed medication(s) for this condition (or related condition)? Yes ◯ No ◯
   If yes, please provide all names

6. Date medication first prescribed? D M Y

7. Was the medication altered in the past 12 months? Yes ◯ No ◯
   If yes, please provide all dates: D M Y | D M Y; D M Y | D M Y

8. If the patient was referred to you, provide name and phone number of referring physician
   Name of Referring Physician | Date of Referral | Telephone No.

9a. Has the patient been hospitalized for this condition (or related condition) in the past 12 months? Yes ◯ No ◯
   If yes, please provide all dates: D M Y | D M Y; D M Y | D M Y

9b. Were follow up treatments required? Yes ◯ No ◯
   If yes, please provide all dates: D M Y | D M Y; D M Y | D M Y

10. Was the cancellation or interruption of the trip due to pregnancy? Yes ◯ No ◯
    If yes, what was the expected date of delivery? D M Y

11a. If the patient was the intended traveller: Did you advise the patient not to travel? Yes ◯ No ◯
    If yes, on what date? D M Y

11b. On what date was this condition stable enough to permit the patient to travel? D M Y

11c. How does the above condition affect the patient's ability to travel? Explain:

PHYSICIAN'S STAMP

Name of Physician | Telephone No.

Physician's Signature | Date D M Y

NOTE: THE CLAIMANT IS RESPONSIBLE FOR THE COST OF COMPLETION OF THIS PHYSICIAN'S STATEMENT

Authorization and Release THIS SECTION MUST BE COMPLETED IN FULL BY ALL CLAIMANTS

Authorization to Insurance Carriers and Other Sources:

This authorization will permit Reliable Life Insurance Company or its representative, Pottruff & Smith Travel Insurance Brokers Inc., to use the disclosed information for the purpose of determining my eligibility for coverage under my travel insurance policy and processing my claim. I hereby assign to Reliable Life Insurance Company any benefits obtained from other sources for losses covered under this policy. I also direct these sources to forward payment to Reliable Life Insurance Company for my claims submitted by Reliable Life Insurance Company with regard to these losses. A photocopy, facsimile or electronic copy of this authorization is acceptable. This authorization will also permit Reliable Life Insurance Company to release and share information with any or all parties noted above.

I certify that the statements and particulars given herein together with those on any accompanying documents are complete, true and correct to the best of my knowledge.

I understand the reasons for which I have been asked to consent to the disclosure of my personal information and am aware of the risks or benefits of consenting, or refusing to consent, to the disclosure. I understand that I may revoke this consent at any time by written notification to Reliable Life and/or its representative Pottruff & Smith Travel Insurance Brokers Inc.

I also understand that the making of false or fraudulent statements in connection with a claim for benefits may render the certificate of insurance or the policy void.

CLAIMANT 1 Signature of Insured / Insured's Guardian | Date of Signature D M Y

CLAIMANT 2 Signature of Insured / Insured's Guardian | Date of Signature D M Y

Coverage With Other Insurers and Other Sources THIS SECTION TO BE COMPLETED IN FULL BY ALL CLAIMANTS

You may have travel protection through other sources such as a credit card or your employer. We require the following information in order to coordinate benefits with these sources.

Did you pay in part or in full for your travel arrangements with a credit card? Yes ◯ No ◯	Credit Card No. (First 6 Digits)	Specific Card Type (i.e., CIBC Platinum, VISA)	Name of Cardholder
Employee Group Benefits Plan Or Retired Employee Group Benefits Plan Yes ◯ No ◯	Group Policy No.	Name of Covered Person / Identification No.	Name of Insurance Company
Any other coverage (i.e., Union, Pensioner, Private or Other Policy or Other Sources of Recovery) under which you are entitled to benefits? Yes ◯ No ◯			Policy No.

Name and Address of Insurance Company/Broker

Other Sources: Name and Address of Company

Claimant's (or Parent's) Occupation: Full Time Employment ◯ Self Employed ◯ Part Time Employment ◯ Student ◯ Retired ◯ Unemployed ◯ Other:

Name of Your Employer	Address: No./Street/Suite No.		
City	Province	Postal Code	Telephone No.
Name of Spouse's Employer	Address: No./Street/Suite No.		
City	Province	Postal Code	Telephone No.

Is this claim due to an injury or accident? No ◯ Yes ◯ ▶ Please provide the contact information for the responsible third party: Name / Address / Telephone No.

Authorization and Release of Claimant's Medical Information

THIS SECTION MUST BE COMPLETED IN FULL IF YOUR CLAIM IS BASED UPON YOUR MEDICAL REASONS

Authorization to Physicians, Hospitals, other Health Care Practitioners, Medical Care Facilities, Insurance Carriers, any other Person who has attended or examined me and Other Sources:

I hereby authorize and direct that you release to Reliable Life Insurance Company or its representative, Pottruff & Smith Travel Insurance Brokers Inc., any and all information you have regarding me, while under your professional care, including my medical history, any illness, injury, consultation, medicines or treatment and copies of all hospital and medical records. This authorization will permit Reliable Life Insurance Company to use the disclosed information for the purpose of determining my eligibility for coverage under my travel insurance policy, assessing insurance risks, managing my claim and negotiating or settling payments to third parties. This authorization will permit Reliable Life Insurance Company's representative, Pottruff & Smith Travel Insurance Brokers Inc., to use the disclosed information for the purpose of determining my eligibility for coverage under my travel insurance policy and processing my claim. I hereby assign to Reliable Life Insurance Company any benefits obtained from other sources for losses covered under this policy. I also direct these sources to forward payment to Reliable Life Insurance Company for my claims submitted by Reliable Life Insurance Company with regard to these losses. A photocopy, facsimile or electronic copy of this authorization is acceptable. This authorization will also permit Reliable Life Insurance Company to release and share information with any or all parties noted above.

I certify that the statements and particulars given herein together with those on any accompanying documents are complete, true and correct to the best of my knowledge.

I understand the reasons for which I have been asked to consent to the disclosure of my personal information and am aware of the risks or benefits of consenting, or refusing to consent, to the disclosure. I understand that I may revoke this consent at any time by written notification to Reliable Life and/or its representative Pottruff & Smith Travel Insurance Brokers Inc. I also understand that the making of false or fraudulent statements in connection with a claim for benefits may render the certificate of insurance or the policy void.

Date of Consent D / M / Y	End Date of Consent: 12 Months from Date of Signature	Signature of Insured / Insured's Guardian	Date of Signature D / M / Y

Authorization to Attending Physician (APPLICABLE TO THE PERSON WHOSE MEDICAL CONDITION WAS THE CAUSE OF CANCELLATION OR INTERRUPTION)

Authorization to Attending Physician:

I authorize you to give Reliable Life Insurance Company or its representative, Pottruff & Smith Travel Insurance Brokers Inc., any and all information you have regarding me, while under observation or treatment by you, including my medical history, diagnoses and test results, as may be required for the adjudication of the claim of

Name of Insured/Claimant	Policy Number		
Patient's Name	Patient's Signature	Date D / M / Y	

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