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CAA TRAVEL INSURANCE
TRAVEL ACCIDENT CLAIM FORM

PLEASE COMPLETE THE FOLLOWING QUESTIONS AND RETURN THIS FORM WITH THE REQUIRED DOCUMENTATION WITHIN 90 DAYS TO ENSURE PROMPT SETTLEMENT OF YOUR CLAIM.	POLICY No.

CASE #	CLAIM #	

1 CAA INSURED INFORMATION

Name:

Address:

Date:

Home Phone Number:

Work Phone Number:

E-mail:

2 CLAIM INSTRUCTIONS

1. VERIFY THAT THE ABOVE INFORMATION IS ACCURATE AND MAKE CHANGES WHERE REQUIRED.
2. COMPLETE THIS FORM IN FULL AND ATTACH ALL DOCUMENTS AS REQUESTED.
3. SIGN AND DATE COMPLETED FORM AND RETURN PACKAGE TO:

   CAA TRAVEL INSURANCE
   9TH FLOOR, 150 COMMERCE VALLEY DRIVE WEST
   THORNHILL, ONTARIO L3T 7Z3

   FOR CLAIMS INQUIRIES PLEASE CONTACT: 1-888-493-0161
   OR CALL COLLECT +1-905-532-2962

FAILURE TO COMPLETE THE CLAIM FORM AND ATTACH REQUESTED DOCUMENTS WILL DELAY THE PROCESSING OF YOUR CLAIM.

PLEASE ATTACH THE FOLLOWING DOCUMENTS:

- ○ TRAVEL ITINERARY CONFIRMING DATE TRIP BOOKED ALONG WITH DEPARTURE AND RETURN DATES
- ○ INVOICE ITEMIZING THE COST OF YOUR TRIP
- ○ MEDICAL REPORTS FROM THE TREATING PHYSICIAN CONFIRMING INJURIES
- ○ ACCIDENT REPORT FROM THE COMMON CARRIER, AIRPORT AUTHORITY OR GROUND TRANSPORT CARRIER
- ○ DEATH CERTIFICATE (IF APPLICABLE)

PLEASE KEEP A COPY OF ALL THE SUBMITTED CORRESPONDENCE FOR YOUR RECORDS.

3 CLAIM DETAILS

YOUR CAA TRAVEL INSURANCE POLICY NUMBER		
NAME OF TRAVEL AGENCY	TELEPHONE NUMBER	
NAME OF AIRLINE/TOUR OPERATOR/COMMON CARRIER	BOOKING DATE (DD/MM/YYYY)	
SCHEDULED DEPARTURE DATE (DD/MM/YYYY)	SCHEDULED RETURN DATE (DD/MM/YYYY)	ACTUAL RETURN DATE (DD/MM/YYYY)
NATURE OF INJURY (IF APPLICABLE)	DATE INCIDENT OCCURRED (DD/MM/YYYY)	
DESCRIPTION OF ACCIDENT		

COMPLETE REVERSE AND ATTACH ALL DOCUMENTS AS REQUESTED IN SECTION TWO

FOR COMPLETE COVERAGE INFORMATION, PLEASE REFER TO YOUR INSURANCE POLICY.

CAA Travel Insurance is underwritten by CAA Insurance Company (Ontario).

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4 OTHER PHYSICIAN INFORMATION

NAME, ADDRESS AND TELEPHONE NUMBER OF ALL PHYSICIANS AND SPECIALISTS THAT THE CLAIMANT HAS SEEN PRIOR TO THE DEPARTURE DATE.

NAME AND SPECIALTY	ADDRESS	TELEPHONE NUMBER
NAME AND SPECIALTY	ADDRESS	TELEPHONE NUMBER

5 OTHER INSURANCE COVERAGE (IF THE INSURED IS A CHILD, THIS SECTION IS APPLICABLE TO THE PARENT OR LEGAL GUARDIAN)

THIS INSURANCE PAYS ELIGIBLE EXPENSES IN EXCESS OF THOSE COVERED BY ANY OTHER INSURANCE. THEREFORE, IF AT THE TIME OF LOSS, YOU HAVE SIMILAR COVERAGE WITH ANOTHER PROVIDER (I.E. CREDIT CARD, TRAVEL INSURER, EMPLOYMENT GROUP HEALTH PLAN, PRIVATE OR PROVINCIAL AUTO PLAN, ETC.), WE WILL COORDINATE BENEFITS IN ACCORDANCE WITH THE CANADIAN LIFE AND HEALTH INSURANCE ASSOCIATION GUIDELINES.

PLEASE PROVIDE DETAILS (ATTACH ADDITIONAL INFORMATION IF NECESSARY)

DO YOU AND/OR YOUR SPOUSE OR CHILD HAVE OTHER FLIGHT & TRAVEL ACCIDENT INSURANCE BENEFITS? (CHECK ALL THAT APPLY)

○ EMPLOYER ○ CREDIT CARD ○ OTHER FLIGHT & TRAVEL ACCIDENT INSURANCE ○ A RETIREE PLAN ○ HOME, AUTO OR OTHER PLAN ○ N/A

1. EMPLOYER, RETIREE OR OTHER GROUP PLAN:

NAME (INSURED, SPOUSE, CHILD): _____

INSURANCE COMPANY: _____ POLICY/PLAN #: _____ ID/CERTIFICATE #: _____

2. CREDIT/BANK CARD:

ISSUING BANK: _____ CARD NO.: _____

3. INDIVIDUAL PLAN:

NAME (INSURED, SPOUSE, CHILD): _____

INSURANCE COMPANY: _____ POLICY/PLAN #: _____ ID/CERTIFICATE #: _____

4. HOME, AUTO, OTHER PLANS:

INSURANCE COMPANY: _____ POLICY/PLAN #: _____ ID/CERTIFICATE #: _____

INSURANCE COMPANY: _____ POLICY/PLAN #: _____ ID/CERTIFICATE #: _____

INSURANCE COMPANY: _____ POLICY/PLAN #: _____ ID/CERTIFICATE #: _____

○ I HEREBY WARRANT THAT I DO NOT HAVE ANY OTHER FLIGHT & TRAVEL ACCIDENT INSURANCE COVERAGE. (CHECK IF APPLICABLE)

6 CERTIFICATION AND AUTHORIZATION

THE INSURER, ITS AGENTS AND ADMINISTRATORS ARE OBLIGED TO COLLECT AND RETAIN CERTAIN PERSONAL AND/OR HEALTH INFORMATION ABOUT YOU IN CONNECTION WITH YOUR INSURANCE COVERAGE. THEY USE AND DISCLOSE THAT INFORMATION ONLY FOR THE PURPOSES OF ADMINISTERING YOUR POLICY/POLICIES OF INSURANCE, PROVIDING CUSTOMER SERVICE AND ASSESSING AND PAYING CLAIMS.

I CERTIFY THAT THE INFORMATION I PROVIDE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS CLAIM SHALL BE VOID IF, WHETHER BEFORE OR AFTER THE LOSS, I CONCEALED OR MISREPRESENTED ANY FACTS, OR IF ANY DOCUMENTS RECEIVED REGARDING THIS CLAIM HAVE CONCEALED OR MISREPRESENTED ANY ANY FACT OR CIRCUMSTANCES CONCERNING THIS CLAIM.

I AUTHORIZE ANY LICENSED PHYSICIAN, MEDICAL PRACTITIONER, HOSPITAL, CLINIC, OTHER MEDICAL FACILITY OR PROVIDER OF HEALTH CARE, INSURER OR REINSURER, PROVINCIAL HEALTH INSURANCE PLAN AND EMPLOYER(S) TO PROVIDE ORION TRAVEL INSURANCE COMPANY, AND ITS REPRESENTATIVES EMPLOYED TO ASSIST IN THE ADMINISTRATION OF THIS CLAIM, ANY INFORMATION, INCLUDING PERSONAL INFORMATION, DATA OR RECORDS THAT ARE IN THEIR POSSESSION/KNOWLEDGE REGARDING MY MEDICAL HISTORY AND TREATMENT.

I DIRECT AND AUTHORIZE MY GOVERNMENT HEALTH INSURANCE PLAN (GHIP) TO MAKE PAYMENT IN RESPECT OF MY CLAIM FOR OUT-OF-COUNTRY HEALTH SERVICES TO ORION TRAVEL INSURANCE COMPANY, DIRECTLY AND I HEREBY RELEASE GHIP, UPON PAYMENT TO ORION TRAVEL INSURANCE COMPANY, FROM ANY FURTHER CLAIM OR CAUSE OF ACTION IN CONNECTION HEREWITH.

I HEREBY CONSENT AND AUTHORIZE GHIP TO DIRECTLY OR INDIRECTLY COLLECT INFORMATION CONTAINED IN THE CLAIM AND SOURCE DOCUMENTS PURSUANT TO THE FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT, AND THE HEALTH INSURANCE ACT.

I AUTHORIZE ORION TRAVEL INSURANCE COMPANY, TO COORDINATE THE PAYMENT OF BENEFITS WITH ANY OTHER INSURANCE CARRIERS WHICH MAY ALSO HAVE A LIABILITY FOR THIS CLAIM. I HEREBY IRREVOCABLY DIRECT ORION TRAVEL INSURANCE COMPANY, TO MAKE ANY PAYMENTS, RECEIVE PAYMENTS AND SETTLE WITH OTHER CARRIERS ON MY BEHALF.

I HEREBY CONSENT TO THE USE BY CAA, THE INSURER, ITS AGENTS AND ADMINISTRATORS OF THE PERSONAL AND HEALTH INFORMATION ABOUT ME DISCLOSED HEREIN AND IN ALL DOCUMENTS OR INFORMATION PROVIDED IN CONNECTION WITH MY POLICY/POLICIES OF INSURANCE FOR THE PURPOSES CITED ABOVE.

ATTENTION TO TRAVEL SERVICE PROVIDERS: I HEREBY AUTHORIZE AND DIRECT THAT YOU RELEASE TO ORION TRAVEL INSURANCE COMPANY OR ITS REPRESENTATIVE ANY AND ALL INFORMATION YOU HAVE REGARDING MY TRAVELS OR USE OF YOUR TRAVEL SERVICES FOR THE PURPOSE OF DETERMINING MY ELIGIBILITY FOR COVERAGE AND OR FOR BENEFITS UNDER MY CAA TRAVEL INSURANCE POLICY.

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. THIS AUTHORIZATION SHALL BE CONSIDERED VALID FOR THE DURATION OF THE CLAIM, BUT NOT TO EXCEED ONE YEAR FROM DATE SIGNED.

INSURED (PRINT FULL NAME): _____

IF INSURED IS DEPENDENT PRINT FULL NAME OF PARENT OR GUARDIAN,
OR IF INSURED IS DECEASED PRINT FULL NAME OF EXECUTOR: _____

SIGNATURE: _____ **DATE:** _____

FOR COMPLETE COVERAGE INFORMATION, PLEASE REFER TO YOUR INSURANCE POLICY.