Insurance Travel Roadside Rewards

TRIP CANCELLATION & INTERRUPTION CLAIM FORM

Policy No. _____
Case No. _____
Form No. ORTCI052017E

HOW TO COMPLETE YOUR CLAIM FORM

Please complete all sections of the claim form. Failure to complete the claim form and attach the requested documents will delay the processing of your claim. Below you will find clarification for the sections of the claim form which are often missed or incomplete.

SECTION B – CERTIFICATION & AUTHORIZATION

This section must be completed in order to release payment of your claim. Completion certifies that the information provided in connection with this claim is complete, true and accurate.

The signed authorization allows ACM to access your personal medical information related to this claim. For the purposes of determining the validity of a claim under this policy, we may obtain and review the medical records of your regular physician(s) at home. Complete the Assignment of Benefits section if you wish to direct payment to a designated person.

SECTION D – OTHER INSURANCE

This section allows us to coordinate payments with any other insurance plans that you may have in addition to this plan such as a group policy through work or coverage through a credit card.

SECTION E – PHYSICIAN'S STATEMENT

Please complete this section **only** if your claim was caused by an injury or illness. This section must be completed by the attending physician of the person whose medical condition caused the cancellation or interruption. If the claim is due to a death, the Physician's Statement is not required. Please submit the death certificate or death notification instead.

SECTION F – EXPENSE SHEET

The first portion refers to the non-refundable and non-transferrable prepaid travel arrangements. These are the **unused** travel arrangements for which you are now seeking reimbursement. The second portion refers to all the additional expenses incurred while on your trip. This section should not be filled out for a Trip Cancellation claim.

*REQUIRED DOCUMENTS

Submit the following documentation to support your claim (please do not staple documents):

- ❑ Travel itinerary or boarding passes: original and new itinerary to show how your travel plans have changed
- ❑ Invoice or proof of payment
- ❑ Proof of cancellation issued by the travel supplier (e.g. airline, hotel, etc.)
- ❑ Proof of any refund
- ❑ Any applicable receipts for out of pocket expenses
- ❑ Proof of the cause of the claim such as a medical report, police report, death certificate or court document
- ❑ Credit Card Statement showing purchase of trip (If trip was purchased on a Credit Card)

SUBMITTING YOUR CLAIM

The completed & signed claim forms and applicable supporting documents can be sent to our office:

- ❑ **Online:** Visit: **https://claims.acmtravel.ca**
  Create an account and upload your required documents.
  Your information is automatically saved and can be reviewed at any time.
- ❑ **By Mail:** **Active Care Management**
  P.O. Box 308, Station A
  Windsor, ON N9A 6K7
- ❑ **By Email:** **OrionClaims@acmtravel.ca**
- ❑ **By Fax:** **1-877-432-9226**

Please save all original receipts and supporting documentation. ACM reserves the right to request original documents when necessary to adjudicate your claim.

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Your travel insurance policy is underwritten by **Orion Travel Insurance Company** ("Orion"). Orion has appointed Active Claims Management, Inc., operating as Active Care Management ("Agent" or "ACM"), as the provider of all assistance and claims services under the policy.
IMPORTANT: The Authorization section must be completed in order to process your claim.
By signing this form you certify that the information provided in connection with this claim is complete, true and accurate.

SECTION A – CLAIMANT INFORMATION

Please attach list if more lines are required

Claimant Name		Date of Birth		
1	☐ Male ☐Female	MM	DD	YYYY
2	☐ Male ☐Female	MM	DD	YYYY
3	☐ Male ☐Female	MM	DD	YYYY
4	☐ Male ☐Female	MM	DD	YYYY

Home Address		
Email	Primary Phone Number	Secondary Phone Number

SECTION B – CERTIFICATION & AUTHORIZATION

- The Insurer, its Agents and administrators are obliged to collect and retain certain personal information 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 provided 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 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 the claim, any information, including personal information, data or records that are in their possession/knowledge regarding my medical history and treatment.
- I hereby consent to the use by AMA, 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 of insurance for the purposes cited above. This consent is effective for one year from the date of the services provided and I may revoke this consent in writing at any time by advising AMA Travel Insurance.
- 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.
- 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 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.

If a claimant is a minor, print full name of parent or legal guardian,
or if a claimant is deceased, print full name of executor:

Signature	Date	MM	DD	YYYY

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SECTION C – TRAVEL INFORMATION

Travel Destination (City, Country)

Type of Claim: ☐ Trip Cancellation ☐ Trip Interruption

Reason for trip cancellation or interruption

Trip Purchase Date	MM	DD	YYYY	Policy Purchase Date	MM	DD	YYYY
Original Departure Date	MM	DD	YYYY	Original Return Date	MM	DD	YYYY
Actual Departure Date	MM	DD	YYYY	Actual Return Date	MM	DD	YYYY
Date of Incident	MM	DD	YYYY	Date of Cancellation	MM	DD	YYYY

Travel Agency Information - Please complete if applicable

Travel Agency	Travel Agent Name
Email Address	Phone
Agency Address	

SECTION D - OTHER INSURANCE COVERAGE

Do you have any group benefits available for medical coverage through your employer, your spouse's employer or a retirement plan?

*Name of Insurance Company	*Group Policy	*Member ID
Your Employer/Retirement Plan #	Spouses Employer/Retirement Plan #	Spouse's name Spouse's date of birth

Do you have benefits available through any other travel insurance company or travel supplier? Please provide:

*Name of Other Provider	*Address of Other Provider

Does this claim relate to a Motor Vehicle Accident? If so, provide the following information:

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*Motor Vehicle Insurance Company	*Policy #	*Phone #

As credit cards may maintain travel benefits, did you use a credit card for any of your travel arrangements (flights, hotels, cruises and cars)?

If a Credit Card was used, Provide the name of the issuing bank		First 6 digits & last 4 digits of credit card		
Name of Primary Insured / Name of Cardholder as it Appears on the Card	Date of Birth	MM	DD	YYYY
Signature of Primary Insured / Cardholder	Date	MM	DD	YYYY

If you have claimed with any other insurer, please provide your claim number and attach a copy of the settlement.

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SECTION E - PHYSICIAN'S STATEMENT

This statement should be completed and signed by the medical physician who treated the injury or illness resulting in this claim.
IMPORTANT NOTICE: Any reference to testing, tests, test results, or investigations **excludes** genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

Patient's Name	Date of Birth	MM	DD	YYYY			
Date symptoms first occurred		MM	DD	YYYY			
Date of first consultation		MM	DD	YYYY			
Date patient advised not to travel		MM	DD	YYYY			
Date patient will be fit to travel		MM	DD	YYYY			
Diagnosis or description of illness / injury							
Was the patient hospitalized? ☐ No ☐ Yes – From:	MM	DD	YYYY	To:	MM	DD	YYYY
All dates of examinations/treatments for this condition from initial consult to present:							
List the medication prescribed for this condition:							
Has the patient ever experienced this illness or a similar problem before? ☐ No ☐Yes – Date:					MM	DD	YYYY
Is this condition a complication of an underlying condition? ☐ No ☐ Yes - please specify:							
If the condition was due to a pregnancy, provide the expected date of delivery					MM	DD	YYYY
Date pregnancy was confirmed					MM	DD	YYYY
If patient was referred to you by another physician, provide the date of referral					MM	DD	YYYY
Referring Physician's name					Phone		

Physician's Certification - I certify that the information provided is complete, true and accurate to the best of my knowledge.

Attending Physician's Name	Physician's Stamp			
Phone				
Fax				
Physician's Signature		MM	DD	YYYY

Patient's Authorization - I hereby authorize any doctor, hospital or facility providing medical or health-related services and any other insurer to release and exchange with Orion and/or ACM or its representative, any information that is required to process this claim. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of patient	MM	DD	YYYY

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SECTION F – EXPENSE SHEET

Unused Travel Arrangements for Trip Cancellation & Interruption

Please include copies of the Travel Supplier invoices, receipts and itineraries for all pre-paid unused travel arrangements.
The travel insurance premium is non-refundable.

Description	Amount Paid	Amount Refunded	Amount Claimed	Currency

Out of Pocket Expenses for Trip Interruption

Please list expenses for:

- additional transportation
- accommodations
- meals
- essential phone calls
- taxi fares

Receipts must be provided when claiming these benefits. Your policy may limit the amount payable per day or per trip.

Description	Date			Amount Claimed	Currency
	MM	DD	YYYY		

If more space required, please attach separate page.