

**CLAIMS PROCESS**

- A. Complete both pages of this form.
- B. Sign the « Assignment of Benefits » section if applicable.
- C. Sign the « Agreement and Authorization » section. If the beneficiary is a minor, a parent or legal guardian must sign the form.

**SEND THIS DULY COMPLETED FORM ALONG WITH ALL OTHER REQUIRED DOCUMENTS TO CANASSISTANCE**

Online via our secure website:

[canassistance.com/en/policyholder/depot](http://canassistance.com/en/policyholder/depot)

Send all scanned documents and keep originals. We reserve the right to request the original documents up to one year from the date of submission of your claim.

By regular mail:

CanAssistance, Travel Claims Department  
PO BOX 3888, Station B, Montreal, Quebec, H3B 3L7

INSURANCE COMPANY	GROUP NUMBER (Optional)
CONTRACT NUMBER	FILE NUMBER (Optional)

**Policyholder**

Last name	First name	Date of birth Year   Month   Day	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Email		Telephone 1	Telephone 2
Country of origin		Relationship to beneficiary (if different from policyholder)	
Address in Canada no   Street   Apt.   City   Province   Postal Code			

**Assignment of benefits**

Are eligible benefits payable to a person other than the policyholder?  Yes  No If yes, please specify who the cheque should be issued to.

Name and address of the person: \_\_\_\_\_

Signature of policyholder \_\_\_\_\_

**Beneficiary (if different from policyholder)**

Last name	First name	Date of birth Year   Month   Day	Gender <input type="checkbox"/> M <input type="checkbox"/> F
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**Information about your trip**

<b>Stay in Canada</b> Arrival date in Canada Year   Month   Day   Departure date from Canada Year   Month   Day	<b>Reason for trip</b> <input type="checkbox"/> Vacation <input type="checkbox"/> Immigration <input type="checkbox"/> Studies, name of institution: _____ <input type="checkbox"/> Work, name of employer: _____ <input type="checkbox"/> Other, specify: _____
<b>Stay in the U.S.</b> Departure date from Canada Year   Month   Day   Return date to Canada Year   Month   Day	

**Agreement and Authorization**

1. I hereby agree to assign to Canassurance Insurance Company and CanAssistance Inc. (hereinafter called the Insurer) all benefits payable by third parties for losses covered under the policy. Furthermore, following the application for reimbursement from CanAssistance Inc., I authorize third parties to pay CanAssistance Inc., the benefits payable regarding these losses.
2. I authorize the Insurer to provide the information contained in my claim file to third parties, for their use, within the context of this claim, to determine the benefits payable, if the case arises.
3. I authorize the Insurer to make payments pertaining to the expenses claimed, directly, when required, to any institution and/or any other provider of services.
4. To assess my application for benefits, I authorize any licensed physician, practitioner, hospital or medical institution, insurance company, or any other agency, institution or person, who have information necessary to analyze my application, to convey that information to the Insurer. I understand that said information may be disclosed when required to its reinsurers, to internal and external auditors and to any professional or organization mandated by the Insurer within the context of processing my application for benefits. This authorization is valid until the final settlement of my claim.
5. I declare that the information and details given on this form and the information provided in the attached documents are complete and true, and I am aware that any false declaration shall nullify the insurance certificate or insurance policy and shall result in the denial of my application for benefits.
6. By sending us this form, you understand that we will process your personal information in accordance with the terms of our Privacy Policy. We invite you to read our Privacy Policy available on our web site, which provides, without limitation, information about the categories of third parties to whom it is necessary to communicate your personal information, sometimes outside your province of residence, and your rights to access and correct your personal information.

Signature of Policyholder or legal heir: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Beneficiary (if different from policyholder): \_\_\_\_\_ Date: \_\_\_\_\_

# CLAIM FORM – VISITORS TO CANADA



FOR OFFICE USE

## Services and care received

Date when first symptoms appeared or accident occurred City and country where services were received

Year    Month    Day

Indicate the reason why you received medical and/or hospital care

\_\_\_\_\_

\_\_\_\_\_

Describe services received (e.g.: examination, x-ray, surgery, etc.). Please use a separate sheet if needed.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If claiming due to an accident, please specify:

Date of accident Type of accident

Year    Month    Day     Motor vehicle    Work    Other, specify: \_\_\_\_\_

## Amount Claimed

Amount claimed: \_\_\_\_\_

Currency:

Canadian Dollars

Other, specify: \_\_\_\_\_

Were bills paid?

Yes

No

If yes, please specify:

Totally

Partially \_\_\_\_\_

Paid amount

## Other Insurance

Do you, your spouse or child have another travel insurance    Yes    No   If yes, please provide the following information:

Policyholder \_\_\_\_\_ Insurance Company \_\_\_\_\_

Policy number \_\_\_\_\_ Company phone number \_\_\_\_\_

Identification number \_\_\_\_\_

Have you already initiated a claim?    Yes    No   If yes, please indicate the file number: \_\_\_\_\_

## Medical Information

**If the beneficiary consulted a doctor or specialist in the 6 months preceding the effective date of the policy, please provide:**

Physician name / Medical Facility	Telephone / Email	Nature of the illness or accident	Date of service

**If the beneficiary was hospitalized in the 12 months preceding the effective date of the policy, please provide:**

Hospital name	Telephone / Email	Nature of the illness or accident	Admission date
			Year    Month    Day

Address (city and country)	Discharge date
	Year    Month    Day

**Please provide the names of all the medicines the beneficiary was taking in the 6 months preceding the effective date of the policy:**

\_\_\_\_\_

\_\_\_\_\_

## Essential Documents to Submit

- This duly completed and signed form.
  - If more than one person received care, you will need to complete a claim form for each person.
  - If the claim involves a person who is a minor, the policyholder or legal heir must sign the form.
- The detailed invoices and proof of payment.
  - Invoices for medical care must show the diagnosis and treatment.
  - Invoices related to the purchase of prescription medication must show the name of the drug, the dosage and the price.
  - Valid proof of payment may include a credit card statement or proof of a deposited cheque, and the currency in which the service was paid must appear. In the absence of a bank or credit card statement, a receipt may be accepted.
- Any other relevant document(s), such as medical reports, lab results, etc.

An incomplete claim may cause additional delays in processing your file. If you can't submit all requested documents, please provide us with an explanation in a letter attached to your claim. We reserve the right to request the original documents or additional information if needed. Please keep a copy of your supporting documents for your records.

Should you have any questions about your claim, please contact us by using the phone number on your insurance card or visit our website at [canassistance.com](http://canassistance.com).

**IMPORTANT NOTICE**

If your claim is deemed admissible, by default a cheque will be sent to the policyholder. If you prefer to receive the reimbursement in your chequing account through direct deposit, please complete this form and attach a voided cheque.

We recommend that you select direct deposit for a number of reasons:

- Avoid the many possible days that come with receiving cheques by mail.
- Access your funds immediately without any holds that may be required by your financial institution.

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**Policyholder identification**

Name of the policyholder

Contract, certificate or identification number

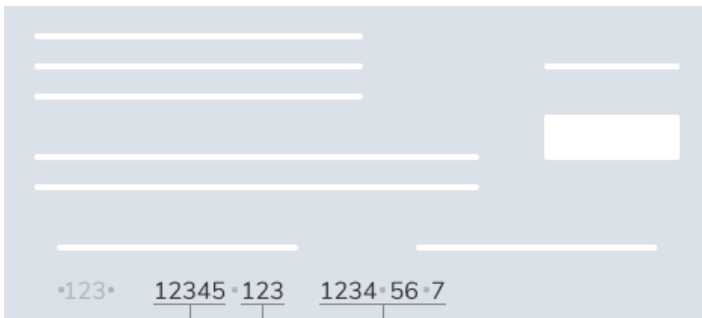
File number

**Bank Account Details (Canadian financial institutions only)**

To avoid payment errors and delays, please attach a voided cheque. A copy can also be obtained through the online banking services of your financial institution.

Scan the document or take a photo of it, making sure all information is legible.

If you are unable to provide a voided cheque, please carefully complete the sections below.



Branch number \_\_\_\_\_

Institution number \_\_\_\_\_

Account number \_\_\_\_\_

•123• 12345 •123 1234 •56•7

1 - Transit (Branch) Number      2 - Financial Institution Number      3 - Account Number

I hereby request that my benefits be paid via electronic funds transfer (direct deposit) to the aforementioned account number.

Signature of the policyholder \_\_\_\_\_

Date \_\_\_\_\_