

CLAIMS PROCESS

- A. Complete both pages of this form.**
- B. Sign the Agreement and Authorization section.**
- C. Compile a list of stolen or damaged items or, in case of delayed baggage, a list of necessary toiletries and clothing.**

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

Online via our secure website:

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, CERTIFICATE OR IDENTIFICATION NUMBER	FILE NUMBER (Optional)

Policyholder

Last name		Gender <input type="checkbox"/> M <input type="checkbox"/> F	
First name		Date of birth Year Month Day	
Email	Telephone 1	Telephone 2	
Mailing address No Street	Apt.	City	Province Postal Code
Is the policyholder submitting a claim? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Claimants (other than policyholder)

Spouse last name	First name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth Year Month Day
Dependent last name	First name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth Year Month Day
Dependent last name	First name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth Year Month Day
Dependent last name	First name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth Year Month Day

Agreement and Authorization

1. I hereby certify that I have not received any compensation for this loss giving rise to this claim other than that declared in this form.
2. I certify that I have not in any way caused or attempted to cause, directly or indirectly, this loss. I have not concealed or misrepresented any circumstances or any relevant facts regarding this coverage and its purposes.
3. I hereby agree to assign to CanAssistance Inc. 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.
4. To assess my application for benefits, I authorize insurance companies, airline companies, travel agents and any other organization or person who have information about me or the loss leading to my claim, to convey that information to CanAssistance Inc. Further, I authorize CanAssistance Inc. to provide my information to the insurer of my travel policy and to its reinsurers, to internal and external auditors and to any professional or organization mandated by CanAssistance Inc. within the context 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 Spouse if they are claiming: _____ Date: _____

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

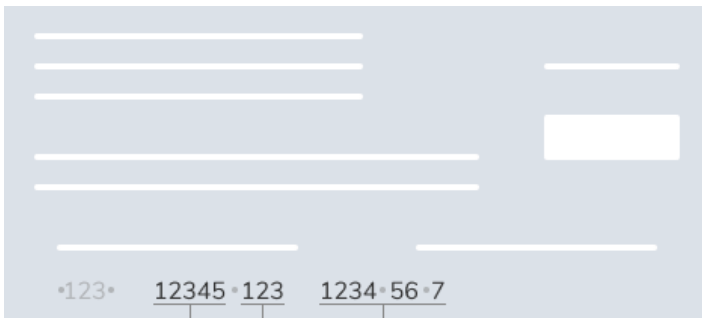
File number

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 _____

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 _____