

**Claims Administration**  
**OLD REPUBLIC INSURANCE COMPANY OF CANADA**  
**RELIABLE LIFE INSURANCE COMPANY**

Box 557, 100 King Street West  
 Hamilton, Ontario L8N 3K9  
**Toll Free:** 888.831.2222  
**Fax:** 866.551.1704

<h2 style="margin: 0;">BAGGAGE CLAIM FORM</h2>
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**Please Note:** *Benefits under any coverage will not be paid for expenses reimbursed or services provided by any other source. Benefits cannot be duplicated under this Protection Plan.*

**PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF THE OCCURRENCE**

<b>Part I</b>				<b>GENERAL INFORMATION</b>			
Claimant's Name <i>(Last, First)</i>			Policy No.		Date of Birth		
Full Address							
Home Phone No.				Business Phone No.			
Tour Operator's Name							
Travel Agency's Name						Telephone No.	
Travel Agency's Full Address							
Departure Date  <i>(MM / DD / YY)</i>		Return Date  <i>(MM / DD / YY)</i>		Departure City		Destination <i>(City, Country)</i>	

<b>Part II</b>			<b>EXPLANATION OF LOSS</b>		
Date of occurrence  <i>(MM / DD / YY)</i>		Time of loss		Location of loss <i>(City, Country)</i>	
Describe fully the circumstances of the loss					

<b>SELECT AND COMPLETE ONE OF THE FOLLOWING:</b>			
<input type="checkbox"/> Property delayed	Amount of Claim (in CDN \$)	Date property returned  <i>(MM / DD / YY)</i>	Please enclose <b>original</b> receipts and written statement from the party responsible for the delay (i.e. Airline, Cruise Line, etc).
<input type="checkbox"/> Property damaged	Amount of Claim (in CDN\$)	Please enclose a report from the responsible party, the <b>original</b> or replacement receipts, or the repair bill.	
<input type="checkbox"/> Property stolen	Amount of Claim (in CDN \$)	Please enclose <b>original</b> or replacement receipts and a police report issued in the City where the property was stolen.	
<input type="checkbox"/> Property lost	Amount of Claim (in CDN \$)	Please enclose <b>original</b> receipts and written statement from the hotel manager, tour guide, or the transportation official (i.e. Airline, Cruise Line, Taxi Company, etc) confirming the date of loss, and the items lost.	

**IMPORTANT – CLAIM CANNOT BE PROCESSED IF THIS FORM IS INCOMPLETE. PLEASE COMPLETE ALL APPLICABLE AREAS.**

Part III SCHEDULE OF LOSS/NECESSARY PURCHASES					
Description of article	Article belongs to	Date & place of purchase	Original Cost (in CDN \$)	Replacement Cost (in CDN \$)	Amount Claimed (in CDN \$)
<b>Total Amount Claimed in CDN \$</b>					
If you have more expenses, please provide a breakdown on an additional sheet using the above format.					

Part IV OTHER COVERAGE			
Was the Property in the custody of an Airline, Cruise Line, Railroad Company, or any other Carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, name of Carrier	
Did you purchase your Property on a credit card? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, name and type of Credit Card (e.g. Visa Gold card)	Do you have any other Insurance Coverage? (e.g. automobile, credit card, etc) <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please complete the following:	
1) Name of Home Owner's Insurance Company	Policy No.	Deductible	Telephone No.
Address of Insurance Company			
Has a Claim been Filed with any other Company? (i.e. airline, cruise line, home owner's, credit card, etc) <input type="checkbox"/> Yes <input type="checkbox"/> No		Claim reference No.	
Has the Claim been settled? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide the outcome of the Claim.	Have you filed previous baggage claims with any other insurance company in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**I DECLARE THAT THE ABOVE INFORMATION IS TRUE, COMPLETE AND CORRECT.**  
*I/We authorize any other insurance plan, under which I/We have coverage, to disclose information as may be necessary or to make payment in respect of my/our claim to Old Republic Insurance Company of Canada/Reliable Life Insurance Company directly. I/We also authorize Old Republic Insurance Company of Canada/Reliable Life Insurance Company to disclose to any other Plan, under which I/We have coverage, any and all information as may be necessary with respect to my/our claim.*

Signature of Insured/Claimant \_\_\_\_\_ Date \_\_\_\_\_ (MM / DD / YY)

Signature of Insured/Claimant \_\_\_\_\_ Date \_\_\_\_\_ (MM / DD / YY)

**IF YOU ARE CLAIMING IN EXCESS OF \$250 THE FOLLOWING NOTARIZATION MUST BE COMPLETED.**

<p><b>THE ABOVE DECLARATION SUBSCRIBED AND SWORN TO BEFORE ME ON THIS</b></p> <p>_____ day of _____ 20_____</p> <p>at _____ Notary Public _____</p>
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