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

TRIP CANCELLATION OR TRIP INTERRUPTION MEDICAL CLAIM FORM

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

Part I GENERAL INFORMATION

Claimant's Name *(Last, First)*	Policy No.	Date of Birth

Full Address

Home Phone No.	Business Phone No.

Full name of all persons claiming	Ages	Relationship to patient *(if applicable)*	Policy No.
1)			
2)			
3)			
4)			

Name or Tour Operator (e.g. Cruise Line, Airline, etc)

Travel Agency's Name	Travel Agent's Name	Telephone No.

Travel Agency's Full Address

Date Initial Deposit Paid for Trip	Date of Final Payment for Trip	Departure Date	Scheduled Return Date	Actual Return Date
(MM / DD / YY)	*(MM / DD / YY)*	*(MM / DD / YY)*	*(MM / DD / YY)*	*(MM / DD / YY)*

Departure City	Destination *(City, Country)*

Part II EXPLANATION OF LOSS

Reason for cancellation/interruption

Date trip was cancelled/interrupted *(MM / DD / YY)*	Total Amount of Claim (in CDN $)	Tour Cost Per Person (in CDN $)	Cruise Cost Per Person (in CDN $)

Air Fare Per Person (in CDN $)	Did you receive a refund from the Travel Agent/Tour Operator after cancellation? ❑ Yes ❑ No	If Yes, Please Indicate the Amount (in CDN $)

Please Indicate Any Additional Expenses Incurred due to the Trip Interruption (e.g. accommodation, transportation, meals)

Type of Expense	Date incurred *(MM / DD / YY)*	Amount
1)		
2)		
3)		

Please enclose the original receipts for the above claimed expenses

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

Part III	**MEDICAL INFORMATION**	
Patient's Name	Nature of injury or sickness	Date symptoms first noticed *(MM / DD / YY)*
For Injury, when, how and where did the accident occur?		Date of first consultation *(MM / DD / YY)*
For Sickness, describe onset, diagnosis and treatment		Date of first consultation *(MM / DD / YY)*
If hospitalized please indicate the name and address of Hospital	Date of confinement From: *(MM / DD / YY)*	To: *(MM / DD / YY)*
Name of Family Physician	Telephone No.	Fax No.

Part IV	**OTHER COVERAGE**	
Did you purchase any portion of your trip on a Credit Card? ❑ Yes ❑ No	If Yes, name and type of Credit Card (e.g. Visa Gold card)	
Do you have any other Insurance Coverage/Plans? (e.g. Travel, Credit Cards, etc) ❑ Yes ❑ No	Has your loss been reported to any other Insurance Company? ❑ Yes ❑ No	If Yes, which Company?
1) Name of Insurance Company	Policy No.	Telephone No.
Address of Insurance Company		
2) Name of Insurance Company	Policy No.	Telephone No.
Address of Insurance Company		
3) Name of Insurance Company	Policy No.	Telephone No.
Address of Insurance Company		

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 Companyto 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)* _____

Part V TO BE COMPLETED BY INSURED

Patient's Name _____ Patient's Date of Birth *(MM/DD/YY)* _____ I _____ I _____

Insured's Name _____ Insured's relationship to Patient _____

Policy No. _____ Policy purchase date *(MM/DD/YY)* _____ I _____ I _____

Scheduled departure date *(MM/DD/YY)* _____ I _____ I _____ Scheduled return date *(MM/DD/YY)* _____ I _____ I _____

Part VI ATTENDING PHYSICIAN'S STATEMENT - TO BE COMPLETED BY THE PHYSICIAN

1. Diagnosis - Nature of Injury or Sickness causing Cancellation/Interruption *(Please Be Specific)*
   a) Primary Diagnosis _____
   b) Secondary Diagnosis _____
2. a) When did symptoms first appear or injury occur? *(MM/DD/YY)* _____ I _____ I _____
   b) When did Patient first consult you? *(MM/DD/YY)* _____ I _____ I _____
   c) If Patient was referred from another physician, name of other physician. _____ Tel No. (_____) _____
   d) If Patient was referred to another physician, name of other physician. _____ Tel No. (_____) _____
   e) Names & Contact Numbers of all other physicians involved. _____
3. Was the Patient's condition Stable and Controlled (as per policy definition below) prior to the trip booking date? ❑ Yes ❑ No
   If Yes, from what date? *(MM/DD/YY)* _____ I _____ I _____
4. Dates of all medical visits as it relates to the condition causing Cancellation/Interruption:

	Date of Consultation (MM/DD/YY)	*Describe the Condition/Treatment*	*Medication Prescribed/Changed*
a)	_____ I _____ I _____	_____	_____
b)	_____ I _____ I _____	_____	_____
c)	_____ I _____ I _____	_____	_____

5. a) Has the Patient been hospitalized for this condition or related condition(s) in the past 12 months? ❑ Yes ❑ No
   b) If Yes, date of admittance: *(MM/DD/YY)* _____ I _____ I _____ Date of discharge: *(MM/DD/YY)* _____ I _____ I _____
6. From what date did this condition prevent the Patient from traveling? *(MM/DD/YY)* _____ I _____ I _____
7. If the Patient is not the Insured, from what date was travel precluded for the Insured due to the Patient's condition? *(MM/DD/YY)* _____ I _____ I _____
8. On what date was this condition stable and controlled to permit travel? *(MM/DD/YY)* _____ I _____ I _____
9. a) Did you advise the Patient/Insured to cancel travel plans prior to departure or return home early as a result of this condition? ❑ Yes ❑ No
   b) If Yes, on what date? *(MM/DD/YY)* _____ I _____ I _____ Please explain: _____
   c) If No, on what date was it reasonable for the Patient/Insured to Cancel/Interrupt their travel plans? *(MM/DD/YY)* _____/_____/_____
10. If condition was related to pregnancy, when was the pregnancy first diagnosed? *(MM/DD/YY)* _____ I _____ I _____
    Expected Delivery Date? *(MM/DD/YY)* _____ I _____ I _____
11. Was this injury or sickness the sole cause of the Patient's disability leading to Cancellation/Interruption? ❑ Yes ❑ No
    If No, please explain: _____

Physician's Remarks: _____

_____

_____

Signature of Physician _____ Date Completed: _____ I _____ I _____

Name of Physician: _____ Telephone No. (_____) _____

Address of Physician: _____ Fax No. (_____) _____

Policy Definition - "Stable and Controlled" means the medical condition is not worsening and there has been no alteration in any medication for the condition or its usage nor dosage, nor any Treatment, prescribed or recommended by a Physician or received within the time period specified in this Policy, prior to Your departure date or Policy Effective Date.

Part VII PATIENT CONSENT TO DISCLOSE HEALTH INFORMATION

Patient's full name at time of treatment: _____

Date of birth: (MM/DD/YY) _____ | _____ | _____

Address: _____

Purpose of release: **ADJUDICATION OF TRAVEL INSURANCE CLAIM**

Effective Date of Insurance Coverage: (MM/DD/YY) _____ | _____ | _____

Medical Facilities: (List all doctors consulted for this condition and hospitals where confined)

Name	*Address*	*Telephone No.*	*Fax No.*	*Dates*
_____	_____	_____	_____	_____ | _____ | _____
_____	_____	_____	_____	_____ | _____ | _____
_____	_____	_____	_____	_____ | _____ | _____

You are authorized to give **Old Republic Insurance Company of Canada/Reliable Life Insurance Company** and its affiliates, reinsurers, agents, consumer reporting agency, or independent claims administrator acting on behalf of Old Republic Insurance Company of Canada/Reliable Life Insurance Company, any information concerning insurance coverage, medical care, advice, treatment or supplies, or any other information that may have bearing on the request for benefits submitted in conjunction with the travel insurance policy.
Information to be released:

All medical records of the Patient for up to 5 years before the Effective Date of Insurance Coverage as shown above through the date of this consent as shown below as applicable based on the patients age as outlined the policy. "Medical records" includes, without limitation, diagnosis list, medication list, physician dictation, office notes, physical therapy records, occupational therapy records, pathology reports, cytology reports and the results of all laboratory tests.

Send to: **Travel Claims Department**
P.O. Box 557, 100 King St. W.
Hamilton, ON L8N 3K9
Telephone: 1-888-831-2222 Fax: (905) 528-8338

By signing below, I understand that:

1. The information in my health record may include information relating to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I have the right to revoke this consent at any time by providing my written revocation to the facility where my records are kept.
3. A revocation will not apply to information that has already been released in response to this consent.
4. A revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. Unless otherwise revoked, this consent will expire in six months.
6. Consenting to the disclosure of this health information is voluntary. I can refuse to sign this consent.
7. Any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I authorize Old Republic Insurance Company of Canada/Reliable Life Insurance Company to disclose my health or claim information to any relevant source (e.g. airline, tour operator, travel suppliers, etc.) for the purpose of obtaining recoveries or any outstanding refunds after my insurance claim has been settled. I hereby assign to Old Republic Insurance Company of Canada/Reliable Life Insurance Company any benefits or recoveries obtained from these sources for losses covered under this policy. I direct these sources to forward reimbursement to Old Republic Insurance Company of Canada/Reliable Life Insurance Company with regard to these losses.

Signature of patient or authorized person: _____ Date: (MM/DD/YY) _____ | _____ | _____

Relationship/Reason patient is unable to sign: _____