ORION TRAVEL INSURANCE™

Trip Cancellation Claim Form

Policy No.:_____ Claim No.:_____

Section A - Policyholder's Information (Please print)

Last Name	First Name	Initials

Date of Birth _____ /_____ /_____ (M/D/Y)	❍ Female ❍ Male

Address (Number & Street)		
City	Province	Postal Code

Phone Number	Alternate Phone Number

Email	Preferred Method of Communication (check all that apply) ❍ Email ❍ Phone ❍ Mail

Section B - Insured Person/Claimant Information (Please print)

Last Name	First Name	Date of Birth _____ /_____ /_____ (M/D/Y)	Relationship to the Policyholder
Last Name	First Name	Date of Birth _____ /_____ /_____ (M/D/Y)	Relationship to the Policyholder
Last Name	First Name	Date of Birth _____ /_____ /_____ (M/D/Y)	Relationship to the Policyholder
Last Name	First Name	Date of Birth _____ /_____ /_____ (M/D/Y)	Relationship to the Policyholder

Section C - Trip Cancellation Information

Claiming for: ❍ Sickness/Injury ❍ Death ❍ Non-Medical Reason

Describe the circumstances which resulted in the cancellation of your trip

Date of the cause of the cancellation _____ /_____ /_____ (M/D/Y)	Original travel dates _____ /_____ /_____ (M/D/Y) to _____ /_____ /_____ (M/D/Y)

Travel Agency Information - please complete if applicable

Travel Agency	Travel Agent Name

Email Address	Phone

Agency Address

Section D - Other Insurance Coverage

This insurance pays eligible expenses in excess of those covered by any other insurance. If, at the time of loss, you have similar coverage with another provider (i.e. credit card, travel insurer, employment group plan, etc.), we will coordinate benefits in accordance with the CLHIA guidelines.

Do you and/or your spouse or child have other travel insurance benefits? ❍ No ❍ Yes If yes, please complete the following sections that apply

Employer, Retiree, Other Group Plan	Name of the Insurance company	Policy No.
Credit Card Coverage	Issuing Bank	Card No. (First 6 Last 4 digits)
Other Coverage	Name of the Insurance company	Policy No.

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 - Declaration / Authorization / Signature

- 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 Orion, 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 services provided and I may revoke this consent in writing at any time by advising Global Excel.
- I authorize Orion Travel Insurance Company and Global Excel, 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 and Global Excel, 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 Orion 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.
- I authorize Global Excel Management (Global Excel) to deposit all personal claim payments directly to the account indicated on this form.

Insured Name: _____

Insured Signature: ✍ _____ **Date** ____ /____ /____ **(M/D/Y)**

If I am not the Insured Person:

- **Use this section if you are completing the claim form on behalf of someone else.**
- In providing this authorization to collect personal information about the Insured Person relating to this claim, I the undersigned do hereby certify that I have appropriate permission from the Insured Person to authorize the collection, use and disclosure of their personal information as authorized above and that the Insurer and its agents and reinsurers may rely and act upon my authorization.
- In the event that the person receiving medical services is an unemancipated child, as defined by the laws of the province of my permanent residence, I hereby state that I am the parent/legal guardian and that the authorization described above applies to his/her medical records.

Authorized Person's Name: _____

Relationship to the Insured Person: _____

Authorized Person's Address: _____

Authorized Person's Signature: ✍ _____ **Date** ____ /____ /____ **(M/D/Y)**

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Section F - Medical Certificate

Note: Please complete this section if the cause for cancellation is the result of sickness or injury.

Part 1 - Patient's Information

Last Name	First Name	Date of Birth _____ /_____ /_____ (M/D/Y)
Address (Number & Street)		
City	Province	Postal Code
Patient's relationship to the Policyholder		

Part 2: Attending Physician's Statement (Must be completed and signed by a licensed medical practitioner)

Diagnosis related to claim (in order of severity):

1: _____

2: _____

Is this a new condition? ❍ No ❍ Yes	If no, what date was this condition first diagnosed: _____ /_____ /_____ (M/D/Y)	Date of first doctor visit for present onset: _____ /_____ /_____ (M/D/Y)
Has the patient received treatment or advice for this condition in the past year? ❍ No ❍ Yes	If yes, please provide all dates: _____ /_____ /_____ (M/D/Y)	
Does the patient take ongoing medication for this condition? ❍ No ❍ Yes	If yes, please provide all names:	
When was the medication last altered? _____ /_____ /_____ (M/D/Y)	Why?	
If patient was referred to you, provide name and phone number of referring physician:		
Was the patient hospitalized? ❍ No ❍ Yes	If yes, Admission _____ /_____ /_____ (M/D/Y) Discharge _____ /_____ /_____ (M/D/Y)	
Name of hospital:		

If condition was due to pregnancy, please complete:

Date of confirmation of pregnancy: _____ /_____ /_____ (M/D/Y)	Expected date of delivery: _____ /_____ /_____ (M/D/Y)

If patient was travelling, please complete:

Did you or the treating physician advise the patient to cancel his/her travel plans? ❍ No ❍ Yes

Patient was not fit to travel from _____ /_____ /_____ (M/D/Y) to _____ /_____ /_____ (M/D/Y)

(If patient is not travelling, please attach documentation indicating medical reason for cancellation)

Note to Physician:
This form has been specifically designed with the Physician in mind. By being comprehensive, it will serve to reduce the physician's administrative workload. Please complete the sections relating to your patient. Request for medical records excludes any genetic test results. Please do not provide any genetic test results. The applicable fees for the completion of this section are the responsibility of the patient.

DECLARATION:

These statements are true and complete to the best of my knowledge and belief.

I agree that I may be contacted for additional information regarding the above patient, including sending copies of medical records if needed.

Attending Physician's Name: _____

Attending Physician's Signature: _____ **Date** ____ /____ /____ **(M/D/Y)**

Registration Number: _____

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Section G - Incurred Expense List

No.	Invoice Description	Purchased Date (MM/DD/YY)	Amount Paid	Currency	Refund Obtained	Outstanding Balance
1						
2						
3						
4						
5						
6						
				Total Amount Claimed		

Section H – Preferred Method of Reimbursement

Note: If a method of reimbursement is not selected, eligible reimbursements under this policy will be issued by cheque.

Assignment of Benefits

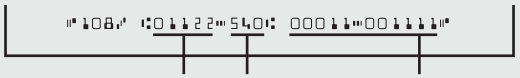
If you wish to direct payment to a designated person other than the claimant, please provide their name, address and phone number below.

Payee Name: _____ Phone Number: _____

Address: _____

❍ **Direct deposit (CAD only).**

By providing your banking information, your claim payments will be deposited directly to your account and you will get an email notification when your claim is settled.



Transit Number: Institution number: Account Number:

❍ **Cheque**

This policy is underwritten by Orion Travel Insurance Company. Orion Travel Insurance Company (Orion) has appointed Active Claims Management (2018) Inc., operating as "Active Care Management", "ACM", "Global Excel Management" and/or "Global Excel" as the provider of all assistance and claims services under this policy.