

IMPORTANT – Required information to process your claim

Date the trip was purchased	Year Month Day	Cost of trip	\$	Type of claim Trip cancellation Delayed or cancelled flight Trip interruption Delayed return Other, specify: _____
Date the trip was cancelled with the travel provider	Year Month Day	Amount claimed	\$	
Original departure date	Year Month Day	Planned destination (city and country):		
Original return date	Year Month Day			
Please indicate why the trip was cancelled or interrupted (<i>if necessary, continue on a separate sheet</i>): _____ _____ _____				Have you obtained a credit or refund from your service provider(s)? Yes No <i>If "yes", please attach a copy of the service providers' answer and ensure the details of the refunds and credits received are listed in the table below.</i>

Expenses & Fees Claimed

Fee description	Trip provider (supplier, carrier, online purchase, etc.)	Amount paid (CAD)	Reimbursement and credits already received (CAD)	Claimed amount (CAD)
Ex. : Vacation package	ABC wholesaler	1,000 \$	250 \$	750 \$
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$
				\$

Agreement, Authorization and Subrogation

- 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.
- 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.
- 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.
- 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.
- 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.
- In consideration of the benefits to be paid as per my policy, I hereby assign and subrogate to my insurer, my rights and remedies against anyone and any person who may be responsible or liable for amounts, damage, loss and/or injuries suffered by me and/or one or more of my family members, covered under my contract, up to all the amounts that will be paid by my insurer and thus hereby subrogate my insurer in all my rights and remedies for the said amounts.
- I agree to accept no settlement without the prior approval of my insurer, failing which all amounts paid by my insurer will be reimbursed to it without delay, and I agree and accept to reimburse my insurer any amount that I can receive from anyone and any person who may be responsible or liable for such amounts, damage, loss and/or injury or from any person liable for it, up to the amount paid by my insurer.
- 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 he or she is claiming : _____ Date : _____

Signature of the dependant, if she or he is of legal age : _____ Date : _____

SEND THE 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
1981, McGill College Avenue, Suite 400, Montreal, Quebec H3A 2W9**

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 the direct deposit option, please complete this form and attach a sample 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.

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
1981, McGill College Avenue, Suite 400, Montreal, Quebec H3A 2W9**

Policyholder identification

Name of the policyholder

Contract or certificate number

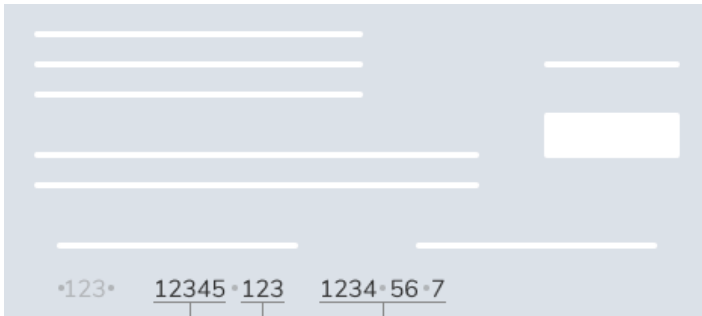
File number

Bank Account Details (Canadian financial institutions only)

To avoid payment errors and delays, please attach a sample 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 sample check, 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) into the aforementioned account number.

Signature of the policyholder _____

Date day / month / year