# TRIP CANCELLATION/INTERRUPTION/ BAGGAGE CLAIM FORM

## INSTRUCTIONS

- Complete all sections and ensure this form is signed before submitting to Intrepid 24/7 with all required supporting documentation.
- Failure to complete and sign this form in its entirety or submit supporting documentation will delay claim processing.
- You are responsible for all fees charged for any supporting documentation.
- The following documents are required:
  - a) A medical certificate completed by the attending physician stating why travel was not possible as booked, if the claim is for medical reasons; or
  - b) A report from the police or other responsible authority documenting the reason for the delay if the claim is due to a misconnection.

  As applicable:
  - a) complete original unused transportation tickets and vouchers;
  - b) original passenger receipts for the new tickets you had to purchase;
  - c) original receipts for the travel arrangements you had paid in advance and for the extra hotel, meal, telephone and taxi expenses you may have had;
  - d) the entire medical file of any person whose health or medical condition is the reason for your claim;
  - e) any other invoice or receipt supporting your claim.

## SECTION A: CLAIMANT

Claimant's First Name: _____ Claimant's Last Name: _____

Date of Birth (MM/DD/YY): _____ Policy #: _____ ◯ Male ◯ Female

Policy Effective Date (MM/DD/YY): _____ Policy Expiry Date (MM/DD/YY): _____

### CLAIMANT'S CONTACT INFORMATION

Street Address: _____ City/Town: _____

Province: _____ Postal Code: _____ Telephone: (_____) _____

Cellular: (_____) _____ Email address: _____

### TRAVEL COMPANIONS (IF APPLICABLE AND COVERED UNDER THIS PLAN)

Travel companion 1:

First Name: _____ Last Name: _____

Telephone: (_____) _____ Email Address: _____

Travel companion 2:

First Name: _____ Last Name: _____

Telephone: (_____) _____ Email Address: _____

Scheduled Departure Date (MM/DD/YY): _____ Scheduled Return Date (MM/DD/YY): _____

Describe the circumstances which resulted in the cancellation of your trip: _____

_____

_____

_____

Date of the cause of cancellation (MM/DD/YY): _____

Date travel agent/airline notified (MM/DD/YY): _____

## SECTION B: OTHER INSURANCE COVERAGE

Do you or your travel companions have any other trip cancellation/ trip interruption insurance? ◯ Yes ◯ No

If yes, provide details of other insurance company coverage below. If no, indicate by checking the box below.

Full Name: _____ Street Address: _____

City/Town: _____ Country: _____

Insurance Company: _____ Policy Number: _____

Credit Card Number (If applicable): _____

Type of Credit Card (If applicable): _____ Contact number: _____

☐ If "No" is selected above, I hereby warrant that I do not have any other travel or medical insurance coverage.

## SECTION C: MEDICAL INFORMATION

Only applicable if trip cancellation or interruption is due to medical reasons.

Description of your sickness or injury (if this space proves insufficient, additional information can be attached).

Diagnosis: _____

Date your symptoms first appeared or the injury occurred (MM/DD/YY):_____

Have you ever been treated for this, or a similar or related, condition before? ◯ Yes ◯ No

Date you first saw a physician for this, or a similar or related, condition (MM/DD/YY): _____

**DETAILS OF TREATING PHYSICIAN (IF APPLICABLE):**

Full Name: _____Clinic Name or Practice: _____

Street Address: _____ City/Town: _____

Country: _____ Postal Code: _____

## SECTION D: OUT OF POCKET EXPENSES

| Name of Provider | Date of Service (MM/DD/YY) | Amount Billed ($) | Amount Paid ($) | Currency |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

## SECTION E: BAGGAGE

Personal Currency:

Describe in detail the loss of personal currency up to $100.00 and attach a copy of the police report.

Baggage Delay:

Describe in detail the delay of the baggage and attach proof of delay of the checked baggage from the common carrier and original purchase receipts.

Wheelchair:

Describe in detail the damage to the wheelchair and provide a receipt for the repairs or a receipt for the rental of a replacement.

## SECTION F: AUTHORIZATION AND CERTIFICATION

Berkley Canada ("Berkley"), Intrepid 24/7 ("Intrepid"), its agents, and administrators, are obliged to collect and retain certain personal and/or health information about you in connection with your insurance coverage. We use and disclose this information only for the purposes of administering your policy/policies of insurance, providing customer service, and in assessing and paying claims. We are committed to protecting the privacy, confidentiality, and security of the personal information we collect, use, retain, and disclose. Your personal information will be used only for the purposes of providing you with the requested insurance services. Berkley's and Intrepid's complete privacy policies are available upon request.

I authorize any doctor, medical practitioner, hospital, or facility providing medical or health-related services, third-party administrator, and any other insurer to release and exchange with Berkley, Intrepid, or its representatives, any information (including personal health data and records) required to process this claim. I authorize any third party providing me with assistance in this claim process to have access to any and all relevant claims information related to the adjudication of my claim with Berkley and Intrepid. I authorize Intrepid to coordinate the payment of benefits with any insurance carriers that may have a liability for this claim and assign to Berkley and Intrepid any benefits payable from any other sources for losses covered under this policy, and authorize and direct such payers to forward payment directly to Berkley and Intrepid. I confirm below by my signature that I am authorized to act on behalf of any of my dependants for these purposes. A photocopy of this authorization shall be as valid as the original. Berkley Canada ("Berkley"), Intrepid 24/7 ("Intrepid"), its agents, and administrators, are obliged to collect and retain certain personal and/or health information about you in connection with your insurance coverage. We use and disclose this information only for the purposes of administering your policy/policies of insurance, providing customer service, and in assessing and paying claims. We are committed to protecting the privacy, confidentiality, and security of the personal information we collect, use, retain, and disclose. Your personal information will be used only for the purposes of providing you with the requested insurance services. Berkley's and Intrepid's complete privacy policies are available upon request.

I authorize any doctor, medical practitioner, hospital, or facility providing medical or health-related services, third-party administrator, and any other insurer to release and exchange with Berkley, Intrepid, or its representatives, any information (including personal health data and records) required to process this claim. I authorize any third party providing me with assistance in this claim process to have access to any and all relevant claims information related to the adjudication of my claim with Berkley and Intrepid. I authorize Intrepid to coordinate the payment of benefits with any insurance carriers that may have a liability for this claim and assign to Berkley and Intrepid any benefits payable from any other sources for losses covered under this policy, and authorize and direct such payers to forward payment directly to Berkley and Intrepid. I confirm below by my signature that I am authorized to act on behalf of any of my dependants for these purposes. A photocopy of this authorization shall be as valid as the original.

I understand my claim may be subject to review and investigation and I give Berkley Canada ("Berkley"), Intrepid 24/7 ("Intrepid"), or their authorized agents authority to acquire any documents or statements from other insurers, financial institutions, travel suppliers, any company or public/private organization which can provide information related to my claim, and I hereby consent to the disclosure of such information to other sources as may be required for the processing of my claim.

I hereby assign any benefits obtainable from other sources for losses covered under this policy. I also direct these sources to forward payment for my claim submitted with regard to these losses. A photocopy or faxed copy of this authorization is acceptable.

I certify that the information provided in connection with this claim is complete, true, and accurate.

Name of Insured (please print): _____

If Insured is a minor, print full name of parent or legal guardian: _____

Signature of Insured (if a minor, signature of parent or legal guardian): _____

Signature of policyholder of other insurance in Section B (if applicable): _____

## SECTION G: ASSIGNMENT OF BENEFITS

This claim is payable to:

◯ Insured at the address in Section A above ◯ Parent/Guardian ◯ Hospital/Clinic ◯ Physician ◯ Other

If applicable, I authorize payment of this claim to (print name): _____

Date signed: (MM/DD/YY): _____

**IN THE EVENT OF A TRIP CANCELLATION OR TRIP INTERRUPTION PLEASE CONTACT INTREPID 24/7 IMMEDIATELY AT:**

1-800-203-8508
toll-free from Canada and the USA

+1-416-646-3107
collect where available

e-mail: **intrepid@intrepid247.com**

**CLAIMS SUBMISSION:**

Intrepid 24/7, 460 Richmond Street West, Suite 100,
Toronto, ON, M5V 1Y1

e-mail: **claims@intrepid247.com**