Manulife

TRIP CANCELLATION & INTERRUPTION CLAIM FORM

Policy No.:
Case No.:
Form No.: MLTCI012020E

HOW TO COMPLETE YOUR CLAIM FORM

Please complete all sections of the claim form. Failure to complete the claim form and attach the requested documents will delay the processing of your claim. Below you will find clarification for the sections of the claim form which are often missed or incomplete.

SECTION B - CERTIFICATION & AUTHORIZATION

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

This signed release allows us to access your personal medical information related to the claim. For the purposes of determining the validity of a claim under this policy, we may obtain and review the medical records of your regular physician(s) at home.

Complete the Assignment of Benefits section if you wish to direct the reimbursement to a designated person. If this section is left blank, any benefits payable under this claim will be assigned to each adult listed on the confirmation of insurance.

SECTION D - OTHER INSURANCE

This section allows us to coordinate payments with any other insurance plans that you may have in addition to this plan such as a group policy through work or coverage through a credit card.

SECTION E - PHYSICIAN'S STATEMENT

Please only complete this section if your claim was caused by an injury or illness. This section must be completed by the attending physician of the person whose medical condition caused the cancellation or interruption. If the claim is due to a death, the Physician's Statement is not required. Please submit the death certificate or death notification instead.

SECTION F - EXPENSE SHEET

The first portion refers to the non-refundable and non-transferrable prepaid travel arrangements. These are the **unused** travel arrangements for which you are now seeking reimbursement. The second portion refers to all the additional expenses incurred while on your trip. This section should not be filled out for a Trip Cancellation claim.

*REQUIRED DOCUMENTS

Submit the following documentation to support your claim (please do not staple documents):

- ☐ Original and new travel itineraries to show how your travel plans have changed
- ☐ Invoice or proof of payment, proof of any refund
- ☐ Proof of cancellation issued by the travel supplier (e.g. airline, hotel, etc.)
- ☐ Applicable receipts for out-of-pocket expenses
- ☐ Proof of the cause of the claim such as a medical report, police report, death certificate or court document
- ☐ Credit Card Statement showing purchase of trip (If trip was purchased on a Credit Card)

SUBMITTING YOUR CLAIM

The completed & signed claim forms and applicable supporting documents can be sent to our office by:

☐ **Online:** Visit: **http://manulife.acmtravel.ca**
Create an account and upload your required documents.
Your information is automatically saved and can be reviewed at any time.

☐ **mail**

Canadian Mailing Addresses		U.S.A. Mailing Address
Active Care Management **P.O. Box 1237** **Station A** **Windsor, ON N9A 6P8**	**Active Care Management** **73 Queen Street** **Sherbrooke, QC J1M 0C9**	**Active Care Management** **535 Griswold St** **Suite 111-605** **Detroit, MI 48226**

☐ **email** **TravelClaims@Active-Care.ca**

Please save all original receipts and supporting documentation. ACM reserves the right to request original documents when necessary to adjudicate your claim.

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Your travel insurance policy is underwritten by **The Manufacturers Life Insurance Company** ("Manulife"). Manulife has appointed Active Claims Management (2018) Inc., operating as Active Care Management ("ACM"), as the provider of all assistance and claims services under the policy.

IMPORTANT: The Authorization section must be completed in order to process your claim.

By signing this form you certify that the information provided in connection with this claim is complete, true and accurate.

SECTION A – CLAIMANT INFORMATION

Please attach a list if there are more than two claimants.

Last Name	First Name		Date of Birth		
1		☐ Male ☐ Female	MM	DD	YYYY
2		☐ Male ☐ Female	MM	DD	YYYY
Address					
Email Address		Primary Phone Number	Secondary Phone Number		

SECTION B – CERTIFICATION AND AUTHORIZATION

All adult claimants must sign below.

- This Authorization will permit Manulife and/or ACM to use the disclosed information for the purpose of determining my eligibility for coverage under my travel insurance policy and discuss any aspect of the adjudication of my claim with Manulife and its affiliates.
- I hereby authorize any doctor, hospital or facility providing medical or health-related services (any of which is a "Provider"), and any other insurer to release and exchange with Manulife and/or ACM or its representative, any information that is required to process this claim.
- I assign to Manulife any benefits payable from any other sources for losses covered under this policy, and I authorize and direct such payors to forward payment directly to Manulife and/or ACM.
- A photocopy, facsimile, or electronic copy of this authorization shall be as valid as the original for the purpose of obtaining further information to process this claim
- Attention to Travel Service Providers: I hereby authorize and direct that you release to Manulife or its representative any and all information you have regarding my travel or use of your travel services for the purpose of determining my eligibility for coverage under my travel insurance policy.
- **Notice**: The provincial legislation in some provinces requires us to inform you that the time limit for taking legal action is set out in the Insurance Act or other legislation that applies to your claim.
- **I certify that the statements and particulars given herein together with those on any accompanying documents or telephone interviews relating to my claim are complete, true and correct to the best of my knowledge.**

Manulife and ACM are committed to protecting the privacy, confidentiality and security of the personal information we collect, use and disclose. Your personal information will be used for the purpose of providing you with the requested insurance services. Your personal information may also be used to contact you about your customer experience and/or to participate in market research. For a copy of the privacy policies, please visit: www.manulife.ca and www.active-care.ca.

If a claimant is a minor, print full name of parent or legal guardian, or if a claimant is deceased, print full name of executor:			
Signature of Claimant 1	MM	DD	YYYY
Signature of Claimant 2	MM	DD	YYYY

Assignment of Benefits Complete this section if you wish to direct the reimbursement to a designated person. If this section is left blank, any benefits payable under this claim will be assigned to each adult listed on the confirmation of insurance.

Payee	Phone
Payee Address	

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SECTION C – TRAVEL INFORMATION

Travel Destination (City, Country)	Type of Claim: ☐ Trip Cancellation ☐ Trip Interruption
Reason for trip cancellation or interruption	

	MM	DD	YYYY		MM	DD	YYYY
Trip Purchase Date				Policy Purchase Date			
Original Departure Date				Original Return Date			
Actual Departure Date				Actual Return Date			
Date of Incident				Date of Cancellation			

Travel Agency Information - please complete if applicable

Travel Agency	Travel Agent Name
Email Address	Phone
Agency Address	

SECTION D - OTHER INSURANCE COVERAGE

Please enter your or your spouse's other insurance coverage for out-of-province travel through an employer group benefit plan, retiree plan or coverage on your credit card.

*Name of Insurance Company	*Policy Number	*Certificate Number

How did you pay for this trip: Credit Card ☐ Cash ☐ Other ☐ ___________________________
*If you paid by credit Card, please include Credit Card Statement showing purchase of trip

If a Credit Card was used, Provide the name of the issuing bank		First 6 digits & last 4 digits of credit card		
Name of Primary Insured / Name of Cardholder as it Appears on the Card	Date of Birth	MM	DD	YYYY
Signature of Primary Insured / Cardholder	Date	MM	DD	YYYY

If you have claimed from any other insurer, please provide your claim number and attach a copy of the settlement.

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SECTION E - PHYSICIAN'S STATEMENT

This statement should be completed and signed by the medical physician who treated the injury or illness resulting in this claim. Any fee for the completion of this form is the patient's responsibility.
IMPORTANT: Any reference to testing, tests, test results, or investigations **excludes** genetic tests.
Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

Field				MM	DD	YYYY
Patient's Name			Date of Birth	MM	DD	YYYY
Date symptoms first occurred				MM	DD	YYYY
Date of first consultation				MM	DD	YYYY
Date patient advised not to travel				MM	DD	YYYY
Date patient will be fit to travel				MM	DD	YYYY
Diagnosis or description of illness / injury						
Was the patient hospitalized? ☐ No ☐ Yes – From:	MM	DD	YYYY To:	MM	DD	YYYY
All dates of examinations/treatments for this condition from initial consult to present:						
List the medication prescribed for this condition:						
Has the patient ever experienced this illness or a similar problem before? ☐ No ☐Yes – Date:				MM	DD	YYYY
Is this condition a complication of an underlying condition? ☐ No ☐ Yes - please specify:						
If the condition was due to a pregnancy, provide the expected date of delivery				MM	DD	YYYY
Date pregnancy was confirmed				MM	DD	YYYY
If patient was referred to you by another physician, provide the date of referral				MM	DD	YYYY
Referring Physician's name				Phone		

Physician's Certification - I certify that the information provided is complete, true and accurate to the best of my knowledge.

Attending Physician's Name	Physician's Stamp			
Phone				
Fax				
Physician's Signature	Date	MM	DD	YYYY

Patient's Authorization - I hereby authorize any doctor, hospital or facility providing medical or health-related services and any other insurer to release and exchange with Manulife and/or ACM or its representative, any information that is required to process this claim. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of patient	Date	MM	DD	YYYY

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SECTION F – EXPENSE SHEET

Unused Travel Arrangements - Trip Cancellation & Interruption
Please include copies of the travel supplier invoices, receipts and itineraries for all pre-paid unused travel arrangements.
The travel insurance premium is non-refundable.

Description	Amount Paid	Amount Refunded	Claim Amount	Currency

Out of Pocket Expenses - Trip Interruption

Please list expenses for:

- additional transportation
- accommodations
- meals
- essential phone calls
- taxi fares

Receipts must be provided when claiming these benefits. Your policy may limit the amount payable per day or per trip.

Description	Date			Claim Amount	Currency
	MM	DD	YYYY		

If more space required, please attach a separate page.

Everyone wants to have a carefree trip and should be able to travel with confidence in their travel insurance purchase. Most people travel every day without a problem, but if something does happen, the member companies of the Travel Health Insurance Association of Canada (ThiA) want you to know your rights. THiA's Travel Insurance Bill of Rights and Responsibilities builds on the golden rules of travel insurance:

Know your health ● Know your trip
Know your policy ● Know your rights

For more information go to www.thiaonline.com