GlobalExcel®

CLAIM FORM

TRIP CANCELLATION AND INTERRUPTION

You must make sure you have completed all sections, signed and dated this form before submitting your claim.

Contract/Policy No.:______________________ Claim No.: ______________________

SECTION A — CLAIMANT INFORMATION (Please print)

Last Name ______________________ First Name ______________________ Date of Birth | M | D | Y |

Address ______________________ Apt. ________ City ______________________

Province ________ Postal Code ________ Home Phone ( ) ______________ Business Phone ( ) ______________

Gov't. Health Insurance Plan Number ______________________ Province ______________________

FAMILY PHYSICIAN Name ______________________

Address ______________________ Phone ( ) ______________

All other Physicians consulted within the last year: ______________________

____

SECTION B — CANCELLATION AND INTERRUPTION

Describe the circumstances which resulted in cancellation/interruption of your trip

____

If you cancelled your trip due to the illness or death of a family member, please state your relationship to that person

Date of the cause of the cancellation: | M | D | Y | Date travel agent notified: | M | D | Y |

Amount claimed $: **Claimant's Signature** Date: | M | D | Y |

SECTION C — OTHER INSURANCE

1. Are you covered by U.S. Medicare? ☐ YES ☐ NO
2. Do you have group (employee/retiree) benefits? ☐ YES ☐ NO
   If YES, please continue, otherwise proceed to question 3.
   Your Group Benefits are through (check all that apply): ☐ Your employer ☐ Your spouse's employer ☐ A retiree plan
   Name of employee/retiree: ______________ Name of employer/group: ______________
   Group no.: ______________ ID no. and/or Cert no.: ______________
   Name of insurance company: ______________
   Does the policy have a lifetime maximum? ☐ YES ☐ NO If YES, indicate lifetime maximum: $ ______________
3. Do you have other travel insurance? ☐ YES ☐ NO
   If YES, please continue, otherwise proceed to question 4.
   Name of insurance company: Policy/ID no.:
4. Do you have any out-of-country benefits? ☐ YES ☐ NO
   IF NO proceed to question 5. If YES, your benefits are through (check all that apply): ☐ Home insurance ☐ Auto insurance ☐ Other
   Name of insurance company: Policy/ID no.:
5. Do you have credit card coverage? ☐ YES ☐ NO
   If YES: Card no.: Bank Name:

THE INSURED IS RESPONSIBLE FOR ANY FEES LEVIED FOR THE COMPLETION OF THIS MEDICAL CERTFICATE

SECTION D — MEDICAL CERTIFICATE

Patient's Name:

Date of Birth: | M | D | Y |

Relationship to Insured:

Patient's Address:

____

Insured's Name:

Scheduled Departure: | M | D | Y | Amount of Claims $:

ATTENDING PHYSICIAN'S CERTIFICATE

(To be completed in full by attending physician for all clinic, office, out-patient and short duration emergency room visits.)

1. Are you this patient's family physician, specialist? Yes ☐ No ☐
   Please specify: ______________________
2. How long have you been this patient's physician? Since | M | D | Y |

DOCTOR: Your certificate will establish the validity of this claim. Please complete fully. Applicable to person whose condition was the cause of the cancellation.

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The Insurance is underwritten by Royal & Sun Alliance Insurance Company of Canada and administered by Expert Travel Financial Security (E.T.F.S.) Inc.

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

50 36 CLM ECA 1208 TRC

SECTION D MEDICAL CERTIFICATE (Continued)

1. I hereby certify that I attended (patient's name) ______________________ for:

(DIAGNOSES RELATED TO CLAIM: LIST IN ORDER OF SEVERITY)

1. ______________________ Date | M | D | Y |
2. ______________________ Date | M | D | Y |
3. ______________________ Date | M | D | Y |

2. (a) Is this a new condition? Yes ☐ No ☐ If "No", on what date was this condition first diagnosed? .... | M | D | Y |

(b) Date of first consultation for present onset: .... | M | D | Y |

(c) Has the patient received treatment or advice for this condition in the last year? Yes ☐ No ☐

If "Yes", please provide all dates: .... | M | D | Y |

(d) To your knowledge, has any other physician treated this patient for this or a similar condition? Yes ☐ No ☐ Please specify who

____

(e) Did the patient make you aware of travel plans? Yes ☐ No ☐ .... | M | D | Y |

(f) Did the patient receive medical approval from you for the trip? Yes ☐ No ☐

(g) If condition was due to pregnancy, what was the expected date of delivery? .... | M | D | Y |

(h) If condition was due to accident, what was the date of occurrence? .... | M | D | Y |

3. (a) Does the patient take ongoing medication for this condition? Yes ☐ No ☐

If "Yes", please provide names: ______________________

(b) When was medication last altered? .... | M | D | Y |

Why? ______________________

4. Was the patient hospitalized? Yes ☐ No ☐ Date of admission | M | D | Y | .... Date of discharge | M | D | Y |

Name of Hospital ______________________

5. (a) In your professional opinion, from what date did this condition preclude travel for the patient or a family member? .... | M | D | Y |

(b) On what date was the patient or family member advised to cancel the trip? [if date different than in 5(a)] .... | M | D | Y |

Why? ______________________

6. On what date was this condition stable enough to permit travel? .... | M | D | Y |

Comments: ______________________

____

Name of Attending Physician (print): ______________________

Signature of Attending Physician: ______________________ Date (M/D/Y): ______________________

Address: ______________________ City: ______________________

Province: ______________________ Country: ______________________

Postal Code: ______________________ Telephone: ______________________

ATTENDING PHYSICIAN'S STAMP

OR ATTACH LETTERHEAD OR PRESCRIPTION PAD

AS INDICATED IN YOUR POLICY, YOUR TRAVEL INSURANCE PLAN PROVIDES COVERAGE IN EXCESS OF YOUR PROVINCIAL HEALTH INSURANCE PLAN AND ANY OTHER APPLICABLE INSURANCE. FOR GLOBAL EXCEL MANAGEMENT INC. TO SEEK REIMBURSEMENT FROM THESE SOURCES YOU MUST COMPLETE THE FOLLOWING SECTION.

SECTION E GENERAL AUTHORIZATION AND RELEASE

1. I assign to Global Excel Management Inc. any indemnity obtainable from other sources for covered losses under this policy. I also direct these sources to forward payment to Global Excel Management Inc. for my claims submitted by Global Excel Management Inc. with regard to these losses and to exchange information that facilitates this process.
2. I authorize any hospital, physician, or medical facility to send my medical information to Global Excel Management Inc., authorized representatives of the Insurer. I further consent to the disclosure of this information by Global Excel Management Inc. to other sources as may be required to obtain benefits from other sources.
3. I warrant that neither I nor any insured person have any additional coverage through any other insurer (other than that listed above).
4. I understand that my insurance shall be void if, whether before or after the loss, any person has concealed or misrepresented any fact or circumstance concerning this claim.

Signature ______________________ **Date** ______________________

For claim inquiries, call Global Excel Management Inc. at 1-877-336-9224 or 819-566-8698.

FOR COMPANY USE ONLY

Fraud Verification A: ______________________ **Fraud Verification B:** ______________________