Claim Form TRIP CANCELLATION AND INTERRUPTION

GlobalExcel

Policy No.: _____

Claim No.: _____

For claim inquiries, call Global Excel Management Inc. or email info@globalexcel.com

Section A - Claimant's Information (please print)

Last Name	First Name	Initials	❑ Female ❑ Male	Date of Birth _____ /_____ /_____ (M/D/Y)
Address (Number & Street)				
City	Province	Postal Code		
Phone 1	Phone 2	Email		

Section B - Policyholder's Information (if different from claimant's)

Last Name	First Name	Initials	❑ Female ❑ Male	Date of Birth _____ /_____ /_____ (M/D/Y)
Address (Number & Street)				
City	Province	Postal Code		
Phone 1	Phone 2	Email		

Section C - Trip Cancellation or Interruption

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

_____

_____

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

Section D - Other Insurance

As indicated in your policy, your travel insurance plan provides coverage in excess of any other applicable insurance.
For Global Excel Management Inc. to seek reimbursement from these sources, please complete the following section.

Do you have credit card coverage? ❑ Yes ❑ No	Card no.	Bank name
Do you have other travel insurance? ❑ Yes ❑ No	Name of the insurance company	Policy number

Section E - Medical Certificate

To be completed only if you are cancelling or interrupting your trip for medical reasons. If not, please go to section F.

Patient's Name		Attending Physician Certificate (to be completed in full by attending physician for all clinic, office, outpatient and short duration emergency room visits)
Date of Birth _____ /_____ /_____ (M/D/Y)	Relationship to the Insured	1. Are you this patient's family physician, specialist? ❑ Yes ❑ No Please specify: _____
Patient's Address		2. How long have you been this patient's physician? Since_____ /_____ /_____ (M/D/Y)
Policyholder's Name		**Doctor: Your certificate will establish the validity of this claim. Please complete fully. Applicable to the person whose condition was the cause of the cancellation.**

Section E - Continued

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

(Diagnoses related to the claim, please list in order of severity)

a. _____ _____ / _____ / _____ (M/D/Y)

b. _____ _____ / _____ / _____ (M/D/Y)

c. _____ _____ / _____ / _____ (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 the 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) If the condition was due to an accident/injury, what was the date of the 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 the medication last altered? _____ / _____ / _____ (M/D/Y)

Why? _____

_____

_____

c) Was the patient hospitalized? ❑ Yes ❑ No Date of admission: _____ / _____ / _____ (M/D/Y) Date of discharge: _____ / _____ / _____ (M/D/Y)

Name of the hospital: _____ Name of the attending physician (print): _____

Signature of the Treating Physician: _____ Date: _____

Address: _____

Telephone: _____

Treating Physician's Stamp
(or attach letterhead or
prescription pad)

SECTION F - GENERAL AUTHORIZATION TO RELEASE

1. I assign to Global Excel Management Inc. any amounts 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.

Claimant or authorized person's signature _____ **Date** _____ / _____ / _____ (M/D/Y)