

# How to Submit a Claim

## TO SUBMIT YOUR CLAIM:

- STEP 1** Gather all your claim documentation
- STEP 2** Complete and sign the claim form
- STEP 3** Complete any other necessary forms
- STEP 4** Complete the checklist below
- STEP 5** Mail all documentation to Allianz Global Assistance

## CHECKLIST

### TRIP CANCELLATION (Before departure)

If you had to cancel your trip do you have:

- The fully completed claim form, signed and dated?  
*Incomplete claim forms will be returned to you and this will delay the processing of your claim submission.*
- Your trip itinerary & copy of itemized invoice showing amount paid for your trip?  
*For example: e-ticket or paper ticket, hotel, taxes, service fees and any other expenses.*
- Proof of payment for your trip?  
*For example: copy of credit and/or debit card statement, cancelled cheques or receipt from travel supplier.*
- Statement from your travel supplier indicating whether a refund and/or credit voucher has been issued or, if no refund and/or credit is available, a copy of the Cancellation Terms and Conditions on the booking(s)?
- If your trip was cancelled for **medical reasons**, do you have:
  - The Trip Cancellation & Interruption Insurance Medical Certificate (completed by a physician)?  
*Further medical documentation may be required by your Claims Examiner.*
  - Copy of the death certificate (if applicable)?
- If your trip was cancelled for **non-medical reasons**, do you have:
  - Supporting documents showing the reason for cancelling your trip?
- A copy of all documents for your records?

## IMPORTANT

- All claims must be reported within 30 days of occurrence.
- Written proof of claim must be submitted within 90 days of occurrence.
- You are responsible for any fees charged for completing this form or issuing supporting documentation.
- This form must be completed by the insured or by a parent or legal guardian if the insured is a minor.

### Send your completed forms and original receipts to:

Allianz Global Assistance Claims Department  
P.O. Box 277  
Waterloo, Ontario N2J 4A4  
Canada

### To check your claim status, please call:

Toll-free Canada/USA: 1- 800- 869- 6747  
Collect worldwide: 416-340-8809  
E-mail: [claims.to@allianz-assistance.ca](mailto:claims.to@allianz-assistance.ca)

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## CHECKLIST

### TRIP INTERRUPTION (After departure)

If you had to interrupt your trip do you have:

- The fully completed claim form, signed and dated?  
*Incomplete claim forms will be returned to you and this will delay the processing of your claim submission.*
- Your **original** trip itinerary (e-ticket or paper ticket) & copy of itemized invoice showing amount originally paid for your trip?
- Your **new** trip itinerary (e-ticket or paper ticket) & copy of itemized invoice showing amount paid to make changes to your trip?
- Proof of payment for your trip?  
*For example: copy of credit and/or debit card statement, cancelled cheques or receipt from travel supplier.*
- Original receipts for any out-of-pocket expenses?  
*For example: hotel, meals, taxi, etc.*
- If your trip was interrupted for **medical reasons**, do you have:
  - The Trip Cancellation & Interruption Insurance Medical Certificate (completed by a physician)?  
*Further medical documentation may be required by your Claims Examiner.*
  - Copy of the death certificate (if applicable)?
- If your trip was interrupted for **non-medical reasons**, do you have:
  - Supporting documents showing the reason for the changes to your itinerary?
- A copy of all documents for your records?

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## SECTION 1: PRIVACY AND DECLARATION

**Allianz Global Assistance Privacy Statement**

Allianz Global Assistance is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

At Allianz Global Assistance, we recognize and respect the importance of privacy. When you enrol for insurance coverage or submit a claim, we establish a confidential file and collect, use and disclose your personal information<sup>1</sup> for the purposes of issuing, administering, adjudicating and/or servicing your insurance. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other persons we have authorized who have a need to know it to perform their duties. Our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security extends to the contracts and agreements we sign with external suppliers and service providers. We may store or process your personal information in Canada, the United States or other countries for processing, storage, analysis or disaster recovery and, under applicable law, governments, courts, law enforcement or regulatory agencies, may, by lawful order, obtain disclosure of your personal information. You can find more details about Allianz Global Assistance's privacy policy at [www.allianz-assistance.ca](http://www.allianz-assistance.ca). If you have any questions regarding our privacy practices, please contact the Privacy Officer at :

AZGA Service Canada Inc.  
o/a Allianz Global Assistance  
P.O. Box 277  
Waterloo, Ontario N2J 4A4  
Canada

Telephone: 416-340-1980  
E-Mail: [privacy@allianz-assistance.ca](mailto:privacy@allianz-assistance.ca)

If you do not agree with our use and disclosure of your information in connection with your application and servicing any policy that we issue, we will not be able to offer you the insurance product you are interested in, service your insurance or adjudicate your claim.

I have read and understood the privacy statement and I consent to the collection, use, retention and disclosure of my personal information or those of my dependants for the purposes stated above. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated.

I hereby assign to AZGA Service Canada Inc. o/a Allianz Global Assistance any benefits obtainable from other sources for losses covered under this policy. I authorize and direct these sources to release payments to Allianz Global Assistance and for Allianz Global Assistance to release pertinent payments to other parties for the purposes of processing my claim.

I certify that the information contained herein is true, complete and accurate and that each of the listed expenses was purchased and/or incurred in connection with the medical treatment of the individual(s) named below. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning this claim, I acknowledge and agree that Allianz Global Assistance may investigate any information about me, my spouse and/or dependents pertaining to this claim, which may be used and disclosed to any relevant Third Party, and where applicable my plan sponsor, for the purpose of investigating and preventing fraud and/or plan abuse.

If I receive payment from Allianz Global Assistance in an amount that exceeds the benefit(s) to which I am entitled under the policy (the "overpayment amount"), then I acknowledge and agree that: (a) I am indebted to Allianz Global Assistance for such overpayment; (b) Allianz Global Assistance has the right to recover the overpayment amount through any means available by law; and (c) Allianz Global Assistance will offset any benefits payable to me by the overpayment amount until Allianz Global Assistance has recovered the overpayment amount in full.

I declare my statements above, including all other past and future statements made through personal or telephone interviews relating to my claim, to be true, complete, current and accurate.

Insured's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

MM/DD/YYYY

Insured's Name (please print): \_\_\_\_\_

Policy #: \_\_\_\_\_

Trip Cancellation &amp; Interruption

## Claim Form

Allianz 

Global Assistance

## SECTION 2: INSURED'S INFORMATION

Insured's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Gender:  M  F  X Date of Birth: MM/DD/YYYY Policy #: \_\_\_\_\_  
 Second Insured's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Gender:  M  F  X Date of Birth: MM/DD/YYYY Policy #: \_\_\_\_\_  
 Phone #: ( ) \_\_\_\_\_  
 Fax #: ( ) \_\_\_\_\_ Email: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Destination: \_\_\_\_\_  
 Scheduled Departure Date: MM/DD/YYYY Scheduled Return Date: MM/DD/YYYY

## SECTION 3: TYPE OF LOSS

Please indicate the general nature of the loss being claimed for:  Trip Cancellation  Interruption  Delays  
 If loss is due to **sickness**, please provide details:  
 Date symptoms or injury first appeared: MM/DD/YYYY Date you first saw physician for this condition: MM/DD/YYYY  
 If loss is due to **injury**, please provide details: \_\_\_\_\_  
 Describe how the injury/accident occurred: \_\_\_\_\_  
 \_\_\_\_\_ Date of injury/accident: MM/DD/YYYY  
 If loss is due to **death**, please provide details:  
 Date of death: MM/DD/YYYY Cause of death: \_\_\_\_\_  
 Your relationship to sick, injured or deceased person: \_\_\_\_\_ Name of patient or deceased: \_\_\_\_\_

**Name and Address of patient's usual Family Physician**  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

**Name and Address of any other physician who may have treated the patient in the last 12 months**  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

If **loss** is due to **other circumstances**, please provide description of loss: \_\_\_\_\_  
 \_\_\_\_\_  
 Date the loss first occurred: MM/DD/YYYY Date you cancelled with travel agent/travel supplier: MM/DD/YYYY

## SECTION 4: EXPENSES CLAIMED

Amounts paid by you will be reimbursed to you, if claim is eligible.  
 You are financially responsible for any expenses not covered by your insurance.

Type of Expense Incurred (airline ticket, hotel, etc.)	Date Incurred	Amount Paid	Currency	Amount Reimbursed/Refunded by Travel Agent or Supplier
1.	<u>MM/DD/YYYY</u>			
2.	<u>MM/DD/YYYY</u>			
3.	<u>MM/DD/YYYY</u>			
4.	<u>MM/DD/YYYY</u>			

**SECTION 5: OTHER INSURANCE COVERAGE**

What method of payment was used to purchase the pre-paid travel arrangements?  Cash  Cheque  Credit Card

If paid by credit card, benefits may be available through the card. Please provide the following:

**Name and address of issuing bank for credit card**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

First 6 digits of credit card #: \_\_\_\_\_ Expiry Date: *MM/YYYY*

Name of Cardholder (please print): \_\_\_\_\_ Cardholder Signature: \_\_\_\_\_

Do you have insurance benefits available through homeowner's insurance, automobile insurance or any other source?

Yes  No If 'Yes', provide details below.

Plan	Name and Address of Insurance Company	Policy #	Telephone
Homeowners Insurance			( )
Tenants Insurance			( )
Travel Insurance other than Allianz Global Assistance			( )
Other			( )

Have you claimed from any other party?

Yes  No If 'Yes', please attach a copy of their settlement or denial.

If the loss was not reported, please provide explanation: \_\_\_\_\_

Insured's signature: \_\_\_\_\_ Date: *MM/DD/YYYY*

**SECTION 6: AUTHORIZATION AND CERTIFICATION**

I authorize any doctor, hospital or facility providing medical or health-related services, and any other insurer to release and exchange with Allianz Global Assistance or its representatives, any personal information<sup>1</sup> that is required to process this claim. I assign to Allianz Global Assistance, 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 Allianz Global Assistance. I also authorize any third party providing me with assistance in this claims process, to have access to any and all relevant claims information related to the adjudication of my claim with Allianz Global Assistance. I confirm I am authorized to act on behalf of my dependants for these purposes. A photocopy of this authorization shall be as valid as the original. I certify that the information provided in connection with this claim is complete, true and accurate.

Full Name of Patient (please print): \_\_\_\_\_

I authorize (insured's name) \_\_\_\_\_

to have access to any and all relevant claims information, including medical records, related to the adjudication of this claim.

Signature of Patient: \_\_\_\_\_ Date: *MM/DD/YYYY*

I authorize payment of this claim to (print name): \_\_\_\_\_

Signature of Insured (if minor, signature of parent or legal guardian): \_\_\_\_\_

Signature of policyholder of other insurance in Section 5 (if applicable): \_\_\_\_\_

<sup>1</sup> **IMPORTANT:** Personal information 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.

Trip Cancellation &amp; Interruption

# Medical Certificate



Global Assistance

**NOTE:** This certificate is to be fully completed and signed by the licensed medical physician who treated the injury/sickness resulting in this claim. Any fee for the completion of this form is the patient's responsibility.

Patient's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Gender:  M  F  X Date of Birth: MM/DD/YYYY Policy #: \_\_\_\_\_

Name of traveller, if different from patient: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Diagnosis/condition resulting in claim: \_\_\_\_\_

Date symptoms first appeared MM/DD/YYYY Date of first medical consultation: MM/DD/YYYY

Date investigative testing began: MM/DD/YYYY Date condition diagnosed: MM/DD/YYYY

Date patient made you aware of travel plans: MM/DD/YYYY

Are you the patient's usual family physician?  Yes  No

If 'No', please provide name, address and telephone number for patient's usual family physician:

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Has the patient suffered from this medical condition in the past?  Yes  No

If 'Yes', please list below the patient's history of this condition and other related conditions over the 12 months prior to this visit:

Date of Consultation	Symptoms Exhibited/Diagnosis	Treatment Rendered
<u>MM/DD/YYYY</u>		
<u>MM/DD/YYYY</u>		
<u>MM/DD/YYYY</u>		

Please provide a list of the patient's current prescription medications: \_\_\_\_\_

Was the condition related to alcohol, misuse of drugs, or self-inflicted injury?  Yes  No

If 'Yes', please provide details:

Was the patient hospitalized?  Yes  No Admission Date: MM/DD/YYYY Discharge Date: MM/DD/YYYY

Name of Hospital: \_\_\_\_\_

Was the visit related to pregnancy?  Yes  No Date of last Menstrual Period: MM/DD/YYYY Expected Delivery Date: MM/DD/YYYY

If 'Yes', please provide specific details: \_\_\_\_\_

Please provide the name and phone number of any other physicians who treated the patient, or referred the patient to you:

Address: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Date the patient was assessed as unfit to travel: MM/DD/YYYY Date you advised traveller not to travel: MM/DD/YYYY

## PHYSICIAN'S CERTIFICATION AND SIGNATURE

I certify that the information provided in this section is complete, true and accurate to the best of my knowledge and belief.

Physician's Signature: \_\_\_\_\_

**PHYSICIAN'S STAMP HERE**

Physician's Name (please print): \_\_\_\_\_

Date: MM/DD/YYYY Email: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

**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.