Manulife

TRIP CANCELLATION & INTERRUPTION CLAIM FORM

Policy No. _____
Case No. _____
Form No. MLTCB052017E

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

SUBMITTING YOUR CLAIM

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

- ❑ **Online:** Visit: **https://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 Address	U.S.A. Mailing Address
Active Care Management **P.O. Box 1237** **Station A** **Windsor, ON N9A 6P8**	**Active Care Management** **535 Griswold St** **Suite 111-605** **Detroit, MI 48226**

- ❑ **Email:** **TravelClaims@Active-Care.ca**
- ❑ **Fax:** **1-877-432-9226**

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

TRIP CANCELLATION & INTERRUPTION CLAIM FORM

Policy No. _____
Case No. _____
Form No. MLTCB052017E

Your travel insurance policy is underwritten by **The Manufacturers Life Insurance Company** ("Manulife"). Manulife has appointed Active Claims Management, 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 only for the purpose of providing you with the requested insurance services. 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	

Manulife

TRIP CANCELLATION & INTERRUPTION CLAIM FORM

Policy No. _____
Case No. _____
Form No. MLTCB052017E

SECTION C – TRAVEL INFORMATION

Travel Destination (City, Country)				Type of Claim: ☐ Trip Cancellation ☐ Trip Interruption			
Reason for trip cancellation or interruption							
Trip Purchase Date	MM	DD	YYYY	Policy Purchase Date	MM	DD	YYYY
Original Departure Date	MM	DD	YYYY	Original Return Date	MM	DD	YYYY
Actual Departure Date	MM	DD	YYYY	Actual Return Date	MM	DD	YYYY
Date of Incident	MM	DD	YYYY	Date of Cancellation	MM	DD	YYYY

Travel Agency Information - please complete if applicable

Travel Agency	Travel Agent Name
Email Address	Phone
Agency Address	

SECTION D - OTHER INSURANCE COVERAGE

Do you or your spouse have any other insurance coverage for out-of-province travel such as an employer group benefit plan, retiree plan or coverage on your credit card? ☐ No ☐ Yes – please specify:

Name of Insurance Company	Policy Number	Certificate Number			
If your credit card offers travel insurance, 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 with any other insurer, please provide your claim number and attach a copy of the settlement.

Manulife

TRIP CANCELLATION & INTERRUPTION CLAIM FORM

Policy No. _____
Case No. _____
Form No. MLTCB052017E

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 NOTICE: 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.

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

Manulife

TRIP CANCELLATION & INTERRUPTION CLAIM FORM

Policy No. _____
Case No. _____
Form No. MLTCB052017E

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			Amount Claimed	Currency
	MM	DD	YYYY		

If more space required, please attach separate page.