TRIP CANCELLATION CLAIM FORM

POLICY NUMBER	CLAIM	SURNAME	FIRST NAME	AGE
DATE POLICY PURCHASED		SCHEDULED DEPARTURE DATE	SCHEDULED RETURN DATE	

Are any benefits provided under any other Insurance Plan? ☐ Yes ☐ No
If yes, complete the following:
Name of Insurer ____
Policy or Contract Number ____
Person Insured ____

Date Travel Agency notified of cancellation, if trip cancelled prior to departure:

Date of Subscriber's return, if return prior to or after scheduled return date:

PLEASE COMPLETE SECTION A OR SECTION B

A. CANCELLATION DUE TO: ILLNESS ☐ INJURY ☐ DEATH ☐

1. Name of Person ill/injured/deceased ____
2. Relationship of Person to Policyholder ____
3. Nature of Illness ____
   or
   Nature of Injury ____
   or
   Cause of Death ____
4. Date of: first symptoms of illness ____ ____ ____
   or
   Date of injury ____ ____ ____
   or
   Date of death ____ ____ ____
5. If an injury, please give accident details (i.e. date, place):
6. Date of first treatment by Physician: ____ ____ ____
7. Name and Address of Physician: ____
8. If hospitalized: Date of Admission: ____ ____ ____
   Date of Discharge: ____ ____ ____
9. Name and Address of Hospital: ____

NOTE: YOU MUST SUBMIT A COMPLETED ATTENDING PHYSICIAN'S REPORT AND IF APPLICABLE A COPY OF THE DEATH CERTIFICATE.

B. CANCELLATION DUE TO OTHER CAUSES:

If cause of cancellation due to any of the following please check ( ) and forward requested documents.

1. ☐ Fire to Subscriber's principal residence rendering it uninhabitable.
   Fire Marshall or Insurance Company report attesting to the fact the residence is uninhabitable.
2. ☐ Subscriber(s) required to move principal residence 160 km (100 miles) or more due to transfer by employer within 30 days of scheduled departure or return date. Letter from employer attesting to the transfer.
3. ☐ Subscriber being called for Jury Duty. Documentation from applicable court confirming subscriber being called.
4. ☐ Subscriber being subpoenaed as a witness. Copy of subpoena.
5. ☐ Subscriber missed scheduled connection at holiday departure point in Canada or Continental U.S.A. due to delay of connecting carrier (airline, bus or train) resulting from weather conditions or mechanical failure.
   Letter from transportation authority attesting to the fact delay due to weather or mechanical failure.
6. ☐ Subscriber being quarantined. Copy of quarantine order from health authority.
7. ☐ Subscriber being hijacked.
   Letter from transportation authority attesting to hijacking incident.

ATTACH APPLICABLE TICKETS AND RECEIPTS AND STATE AMOUNT OF CLAIM — **FOR BLUE CROSS USE ONLY**

	AMOUNT CLAIMED	MANITOBA BLUE CROSS PAYMENT	
1. Pre departure airfare cancellation penalty			209
2. Extra return airfare due to delay or early return			210
3. Prepaid land arrangements cancellation penalty			211
4. Single supplement charge			212
5. Extra airfare costs due to missed connection			213
6. Prepaid land costs due to excessive delay			214
7. Extra transportation costs to rejoin tour			215
TOTAL:			

BAGGAGE OR DELAY LOSS

(This section to be completed for lost or delayed baggage)

Explanation of Delay or Loss ____
Amount of Claim ____
Date of Delay or Loss ____
Delay or Loss reported to : ☐ Airline ☐ Cruise ☐ Train ☐ Busline ☐ Police ☐ Hotel
Location of Delay or Loss ____
Other Insurance in Force ☐ Yes ☐ No
Name of Other Insurance Company ____
Amount paid by other Insurance Company $____

Supporting Documentation required/attached:
1. Copy of official report of loss (airline/train/boat/bus/police/hotel)
2. Proof of payment received from other insurer/travel supplier/other source.
3. Detailed receipts for essential clothing, toiletries purchased, verifying when these items were purchased.
4. CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF LOSS.

I CERTIFY THAT I AM AWARE OF AND HAVE READ THE AUTHORIZATION AND CONSENT ON THE REVERSE SIDE OF THIS CLAIM FORM. I AGREE THAT THIS CLAIM IS TRUE AND CORRECT AND AGREE THAT IT SHALL BE SUBJECT TO THE PROVISIONS OF THE CONTRACT. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL. I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE ENTIRE COST OF SERVICES RECEIVED.

NAME AND ADDRESS OF POLICY HOLDER TO WHOM PAYMENT IS TO BE MADE.

DATE ____ RES. PHONE ____ BUS. PHONE ____

NAME ____

SIGNATURE OF SUBSCRIBER OR LEGAL REPRESENTATIVE ____

ADDRESS ____

IF THERE IS CHARGE FOR COMPLETION OF FORMS IT IS THE RESPONSIBILITY OF THE INDIVIDUAL CLAIMING THE BENEFIT.

ADDRESS ____ POSTAL CODE ____

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P.O. BOX 1046, WINNIPEG, MANITOBA R3C 2X7 • PHONE 775-0151 – CLAIMS AND CUSTOMER SERVICE

MBC 1046-2M-01/2004

AUTHORIZATION AND CONSENT

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba Blue Cross and/or Blue Cross Life Insurance Company of Canada may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the Company's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, the certificate holder of any policy under which I am a participant and other third parties when required to administer the benefits outlined in my policy or the group policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross' privacy policies I can contact Blue Cross at 775-0151 or at www.mb.bluecross.ca should I have questions as to the collection, use or disclosure of my personal information.

I authorize Blue Cross to collect, use and disclose my personal information as described above.