Desjardins Insurance
Life • Health • Retirement

Instructions – Trip Cancellation / Interruption Insurance
Travel Insurance

Submit your claim in 4 steps

Step 1 – Immediately inform your travel service supplier(s) of the cancellation.

Step 2 – Gather all of the necessary documents (see below).

Step 3 – Complete and sign the enclosed Claim – Trip Cancellation / Interruption Insurance – Illness or Injury form.

Step 4 – Send us the form and documents online or by mail:

Online
www.desjardinslifeinsurance.com/send

Mail
Desjardins Insurance
200, rue des Commandeurs
Lévis (Québec) G6V 6R2

Questions?

Call us at 1-855-368-6924

Documents to provide

A completed, signed and dated Claim – Trip Cancellation / Interruption Insurance – Illness or Injury form

Statement of physician consulted section – must be completed by the physician consulted
Page 3 of the enclosed Claim – Trip Cancellation / Interruption Insurance – Illness or Injury form.

The receipt(s) you were given when you purchased your trip
These documents must indicate the amount paid, the trip dates and any deposits paid (if applicable).

Proof of payment for your trip
For example, a copy of your bank or credit card statement.

Documents proving that you cancelled all of the reservations for your trip
These documents must indicate the amounts reimbursed, the cancellation date and any travel credits (if applicable).

Proof of reimbursement of the travel reservation(s)
For example, a copy of your bank or credit statement.

Any unused transportation tickets (if applicable)

A void cheque if you want to receive your payment by direct deposit. Direct deposits can only be made to the contract owner's account.

Additional documents required for trip interruption or delays

A detailed receipt showing the amounts paid to make changes to your trip
For example, new return tickets, any unused land portion of the trip, etc.

Proof of payment for the new tickets
For example, a copy of your bank or credit card statement.

Original and detailed receipts for living expenses (if applicable)
For example, hotel, meals, etc.

To avoid delays

Make sure to fill out everything on the required forms and send us all the requested documents
If we need to return a form to you or ask for missing documents, it will take longer to process your claim.

If you can't attach all the requested documents
Please explain why on a separate sheet of paper and attach it to your claim.

ⓘ Note that we may require additional documents or information.

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Claim – Trip Cancellation / Interruption Insurance Illness or Injury

Travel Insurance

A. Information on the insureds for whom you are claiming expenses

Information on the contract or credit card holder

Contract or credit card number	10-digit daytime phone number	Email address (To follow up on your claim, if necessary)

⚠ **Please complete the table below for each person for whom you are claiming expenses.**

Name	Address	Date of birth (YYYY-MM-DD)	Relationship to contract or credit card holder

B. Information on the trip

Reason for claim (check the box that describes your situation)

☐ Complete cancellation ☐ Delayed departure ☐ Missed connection ☐ Delayed return ☐ Early return

Planned trip dates		Actual trip dates (if departure or return dates changed)	
from (YYYY-MM-DD):	to (YYYY-MM-DD):	from (YYYY-MM-DD):	to (YYYY-MM-DD):
Date of first deposit or payment in full (YYYY-MM-DD)		Date of cancellation with the supplier (YYYY-MM-DD)	

Were you entitled to a refund from the supplier, including a travel voucher, that you accepted or refused?	**Amount** you are claiming from us
☐ Yes ☐ No If yes, how much:	

C. Information on the reason for the claim

Reason and circumstances for cancellation (injury, illness or other) – Please be specific (if you need more space, attach another sheet).

Who is ill, injured or deceased?	Relationship to insured(s)

D. Other coverage

Do you have another insurance contract with trip cancellation coverage? ☐ Yes ☐ No

If yes, provide the following information:

Name of insurance company or credit card: _____ Contract number: _____

Have you submitted a claim to this company? ☐ Yes ☐ No

E. Consent related to the management of your personal information by Desjardins Insurance

This consent applies only to the person who had the injury or health issue.

1. Why Desjardins Insurance needs your consent

Your consent allows us to collect, use and disclose the personal information we require to:

1. Analyze your insurance applications
2. Manage your file while you're covered under the insurance
3. Process claims

Your consent also allows us to do the following, as required:

- Look at information in any old insurance file you may have with Desjardins Insurance
- Ask a personal information broker to provide us with an investigation report about you, if necessary

⚠ Please sign the next page of this form

- Send a summary of your personal information, including health-related information, to MIB, LLC (see text box below), after analyzing an insurance application you've submitted

  MIB, LLC is an organization that operates a database allowing insurance companies in Canada and the United States to collect and disclose information about their clients.
- Send your doctor any medical information that we obtained about you when analyzing your insurance applications or claims, so they can share it with you
- Provide insurers and reinsurers with any relevant information (medical test results, etc.), so they can assess an insurance application you've submitted

By giving your consent to us, you also authorize our reinsurers and our subsidiary Assistel to collect, use and disclose your personal information the same way we would. Our reinsurers are companies that insure us, Desjardins Insurance.

2. Who your personal information will be collected from or disclosed to

You give your consent for the collection and disclosure of the necessary information with you, but also with other people and organizations. These people and organizations include:

- Travel agencies, travel wholesalers, airlines
- MIB, LLC
- Healthcare professionals or establishments (doctors, hospitals, clinics, etc.)
- Healthcare providers
- Paramedical firms
- Public or parapublic organizations
- Insurance companies other than Desjardins Insurance
- Reinsurers
- Your employer or a former employer
- The policyowner (also called policyholder or contract holder), if you aren't that person
- Other Desjardins components, if they're involved in the insurance
- A personal information broker or an investigation firm

3. If the request concerns someone other than yourself

For a minor child

You also authorize us to collect, use and disclose the necessary personal information about them, if they're under age 14 (Quebec) or under age 16 (all other provinces and territories)

For a deceased person

You also authorize us to collect, use and disclose the necessary personal information about them.

By signing this form, you:

- Authorize Desjardins Insurance, its reinsurers and its subsidiary Assistel to collect, use and disclose your personal information based on the conditions outlined in this section, the applicable regulations and Desjardins Group's Privacy Policy. You can consult the policy at www.desjardins.com/privacy-policy
- Declare that the information you have provided here is complete and accurate

F. Signature

X _____ _____

Signature of the person who had the injury or health issue — Date (YYYY-MM-DD)

⚠ **If the person who should sign above is a minor child* or is deceased, the person making the claim must fill out the box in green below:**

* For the purposes of this form, this means under the age of 14 (Quebec) or 16 (all other provinces and territories)

First and last name of the person making the claim (please print)	Signature of the person making the claim **X**	Date (YYYY-MM-DD)

Relationship between the person making the claim and the minor child or the deceased :

Relationship to the minor child:

☐ Parent (father or mother) ☐ Guardian (Quebec)

☐ Legal representative (all other provinces and territories)

Relationship to the deceased:

☐ Liquidator or executor

☐ Other: _____

Physician statement – Note to physician

Please answer the following questions about the diagnosis or health issue that led to the trip being cancelled.

For Desjardins Insurance only

Our file number:

Any fees charged for providing this statement are to be paid by the insured.

A. Statement of physician consulted for the illness or injury

Your patient's name

Date of birth (YYYY-MM-DD)

Injury or health issue warranting cancellation of the trip

Please answer all of the questions below in terms of the injury or health issue that led to the above-mentioned trip being cancelled.

1. Date of injury or initial symptoms (YYYY-MM-DD): _____

2. Date first seen for this injury or these symptoms (YYYY-MM-DD): _____

   a) Was the patient already taking medication for this injury or health issue? ☐ Yes ☐ No

      i. If yes, indicate which medications and the date they were prescribed:

      _____ YYYY-MM-DD

      ii. Did you adjust the medication? ☐ Yes ☐ No If yes, when? _____ YYYY-MM-DD

   b) Did you prescribe new medication for this health issue?
   ☐ Yes ☐ No If yes, specify (drug name, dosage and date):

   _____ YYYY-MM-DD

   c) Has the patient started any new treatment (other than medication) or has it been recommended they do so?
   ☐ Yes ☐ No If yes, indicate new treatments and dates:

   _____ YYYY-MM-DD

   _____ YYYY-MM-DD

   d) Has the patient undergone any tests or has it been recommended they do so for this injury or health issue?
   ☐ Yes ☐ No If yes, indicate tests and dates:

   _____ YYYY-MM-DD

   _____ YYYY-MM-DD

   e) Has the patient undergone any tests for which you are awaiting results?
   ☐ Yes ☐ No If yes, indicate tests and dates:

   _____ YYYY-MM-DD

   _____ YYYY-MM-DD

   f) Has the patient undergone surgery or has it been recommended they do so?
   ☐ Yes ☐ No If yes, indicate surgery and date:

   _____ YYYY-MM-DD

   g) Has the patient been hospitalized? ☐ Yes ☐ No If yes, when: _____ YYYY-MM-DD _____ YYYY-MM-DD

3. If the patient is pregnant, indicate the estimated date of delivery (YYYY-MM-DD): _____

4. Was the patient referred to you by another physician? ☐ Yes ☐ No If yes, indicate:

   a) The referring physician's name and address: _____

   b) The date on which the patient was referred to you (YYYY-MM-DD): _____

5. Did you advise the patient **not to** take this trip? ☐ Yes ☐ No If yes, when? _____ YYYY-MM-DD

B. Identification of physician consulted (please print)

Name

Address

10-digit phone number

Specialty

Signature of physician

x

Date (YYYY-MM-DD)

Physician's seal or a document containing their contact information

C. Identification of family physician – If different from physician indicated above

Name: _____ 10-digit phone number: _____

Print Reset