TD Insurance
TD Trip Cancellation and Trip Interruption Insurance

The Trip Cancellation/Trip Interruption Claim form contains seven (7) sections:

- Section 1: Information about the Primary Cardholder/Certificate Holder
- Section 2: Travel Details
- Section 3: Trip Cancellation and Trip Interruption Details
- Section 4: Summary of Expenses and Refunded Amounts
- Section 5: Other Insurance Coverage
- Section 6: Authorization and Declaration
- Section 7: Medical Information

Note:

- Please print all information using a ball point pen.
- Initial all corrections/changes, including any changes you make with correction fluid (liquid paper).
- Completion of all sections is required and any missing information may result in the delay of the processing of your claim, or the invalidation of your claim.
- Checkboxes are provided below to assist you in completing the claim package.
- If you have any questions, please contact our Administrator at 1-800-293-4941.

Instructions for the Claimant

Check if completed

- ❑ Please complete and sign the attached claim form. Note: Your Claim must be filed within 1 year of incident.
- ❑ If the cause of your claim is medical in nature, please ensure that both parts of **Section 7 - Medical Information** are completed.
  - ❑ Part 1 – Patient's Information.
  - ❑ Part 2 - Attending Physician's Statement must be completed and signed by a licensed medical practitioner.
- ❑ Please provide the following documentation, if applicable, and check the appropriate box for each item included:
  - ❑ Original receipt or invoice, original vouchers and original itinerary showing the itemized cost of your trip
  - ❑ Your monthly credit card statement confirming the trip was charged to your account
  - ❑ Original receipt or invoice showing additional cost incurred due to trip interruption or trip cancellation
  - ❑ Original, unused airline ticket(s) coupon and passenger ticket(s) coupon for return trip
  - ❑ Original ticket(s) or a copy of the refund statement from the travel supplier
  - ❑ Medical report from treating physician indicating diagnosis and treatment or completed medical certificate or death certificate
- ❑ Retain a copy of the completed claim package for your records
- ❑ Return the original forms to:

  Allianz Global Assistance
  P.O. Box 277
  Waterloo, ON N2J 4A4
  Fax: (519) 742-9471

533850 (0915)

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Section 1: Information about the Primary Cardholder/Certificate Holder

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. Case # (if applicable): _____

Certificate # / Credit Card Number: _____
For claims against TD VISA benefits, please provide ONLY the first 6 and last 4 digits only. Otherwise, please enter your Certificate # from your Declaration of Coverage.

Name: _____ Date of Birth: _____
(Last Name) (First Name) (Month, Day, Year)

Address: _____
(Number) (Street)

_____
(City) (Province) (Postal Code)

_____
Home Phone Number Mobile Phone Number Email Address

How may we contact you? ❑ Mail ❑ Email ❑ Home Phone ❑ Mobile Phone
Please check all that apply

Section 2: Travel Details

Original Planned Departure Date: _____ Original Planned Return Date: _____
(Month, Day, Year) (Month, Day, Year)

Actual Return Date: _____
(Month, Day, Year)

Mode of Travel: ❑ Car ❑ Airplane ❑ Other: _____

Date of Initial Trip Deposit: _____ Date of Final Payment: _____
(Earliest date that a payment of any kind was paid and / or applied to your trip.) (Month, Day, Year) (Month, Day, Year)

Date of Incident (Cancellation/Interruption): _____
(Month, Day, Year)

When was the incident reported to us? _____
(Month, Day, Year)

Did our Administrator approve the expenses in advance? ❑ Yes ❑ No

Describe in detail the cause and circumstances related to this claim: _____

Section 3: Trip Cancellation and Trip Interruption Details

Please refer to your Certificate of Insurance for full details of Trip Cancellation and Trip Interruption Coverage. Credit Card customers, refer to the ''Trip Cancellation/Trip Interruption' section of your cardholder agreement.

Cause for Claim:
- ❑ Medical (Please complete Section 7)
- ❑ Death (Please complete section 7 if required by our Administrator)
- ❑ Non-Medical (Not applicable to Annual Plan Policy Holders)

If Non-Medical:
- ❑ Travel Advisory
- ❑ Government Visa
- ❑ Employment/Occupation
- ❑ Delay of Carrier – Weather
- ❑ Delay of Carrier – Mechanical Failure
- ❑ Delay of Private Automobile
- ❑ Other: _____

Source of Claim:
- ❑ An Insured Person / Authorized Card Holder
- ❑ A Travelling Companion (not named on the Certificate)
- ❑ Immediate Family member
- ❑ Not Applicable (Travel Advisory ONLY)
- ❑ Other _____

Section 4: Summary of Expenses

Note: Please include all documentation of cancellation, proof of refund or cancellation penalties, and receipts for all expenses incurred.

Part 1: Claimant Information

	Name of Claimant(s):		Claimant(s)' Date of Birth	Claimant(s)' Relationship to the Primary Cardholder/Certificate Holder
1.	(Last Name)	(First Name)	(Month, Day, Year)	
2.	(Last Name)	(First Name)	(Month, Day, Year)	
3.	(Last Name)	(First Name)	(Month, Day, Year)	
4.	(Last Name)	(First Name)	(Month, Day, Year)	
5.	(Last Name)	(First Name)	(Month, Day, Year)	
6.	(Last Name)	(First Name)	(Month, Day, Year)	
7.	(Last Name)	(First Name)	(Month, Day, Year)	
8.	(Last Name)	(First Name)	(Month, Day, Year)	
9.	(Last Name)	(First Name)	(Month, Day, Year)	
10.	(Last Name)	(First Name)	(Month, Day, Year)	

Part 2: Expense Summary

Note: Please record all expenses and keep records of your receipts.

Trip Cancellation (before departure) or Trip Interruption (after departure) Expenses

	Description	Amount	Currency
1.			
2.			
3.			
4.			
5.			
6.			

Part 3: Refund Summary

Note: Please record all refunds you've already received from any travel suppliers (Airlines, Hotels, Tour Operators, etc.) or other insurance providers. For example: account credits, cash refunds, trip or meal vouchers, etc.

	Description	Amount	Currency
1.			
2.			
3.			
4.			
5.			

Section 5: Other Insurance Coverage

Please indicate all Insurance Certificates which may provide Trip Cancellation and/or Trip Interruption coverage through any other insurer, including employer group benefits, union or pensioner plans, credit cards with embedded travel benefits, or other travel Insurance Certificates. Attach an additional page if required.

1. Name of Insurer: _____ Phone: _____

Address _____
(Number) (Street)

_____
(City) (Province) (Postal Code)

Lifetime Limit on policy? ❑ No ❑ Yes $ _____ Group/ Policy #: _____ Insurance Certificate # or Credit Card #: _____
(if unsure, please contact our Administrator) (Please Specify)
Credit Card #: Provide ONLY the first 6 and last 4 digits.

Name of Primary Cardholder/Certificate Holder: _____

2. Name of Insurer: _____ Phone: _____

Address _____
(Number) (Street)

_____
(City) (Province) (Postal Code)

Lifetime Limit on policy? ❑ No ❑ Yes $ _____ Group/ Policy #: _____ Insurance Certificate # or Credit Card # _____

(if unsure, please contact our Administrator) (Please Specify)

Credit Card #: Provide ONLY the first 6 and last 4 digits.

Name of Primary Cardholder/Certificate Holder: _____

Have you submitted this claim to any other insurance company? ❑ No ❑ Yes

(Please Specify) _____

NOTE: If you are insured under any other insurance certificate or policy, our Administrator will coordinate payment of benefits with the insurer of the above noted policies.

Section 6: Authorization and Declaration

Name of Insured/Cardholder: _____

(Last Name) (First Name)

Address of Insured/Cardholder: _____

(Number) (Street)

_____

(City) (Province) (Postal Code)

- I authorize any physician, hospital or other medical provider who has attended or examined me to release to and exchange with TD Life Insurance Company ("TD Life") and its administrator Allianz Global Assistance ("Allianz") or its representative's any and all information regarding my medical history, symptoms, treatment, examination or diagnoses for the purpose of adjudicating my claim.
- I authorize any other insurance carrier to release and exchange with TD Life and/or TD Home and Auto Insurance Company ("TD Home & Auto") and Allianz or its representatives any medical or benefits payment information relating to this claim.
- The information provided with respect to this claim will be used by TD Life and/or TD Home & Auto and Allianz or their representatives to investigate any losses, assess any entitlement to benefits and to administer this claim, and as otherwise indicated in the privacy terms provided in the Certificate of Insurance. We will investigate and administer this claim by consulting the insurer's existing files and by exchanging information with the undersigned and third parties, such as indicated in this authorization.
- I hereby authorize and request any physician, hospital, clinic, individual, law enforcement or government organization, insurance company, worker's compensation body, current or former employer, or other entity that has any personal and medical records, information or knowledge in regard to the insured or where applicable, any dependents under this insurance coverage, to release and provide full details (including furnishing copies) of all available personal and medical information records and knowledge, including prior medical history, toxicological or pathological findings which they may possess to TD Life and/or TD Home & Auto and Allianz in regard to this claim, its re-insurers or their respective agents. This information is to be used in the evaluation of an insurance claim and for purposes relating to such claim.
- I authorize Allianz (including its representatives or affiliates) to disclose to TD Life and/or TD Home & Auto any information relating to this claim that it may have in its possession including information it obtains from third parties. I am aware that any authorization I provide to Allianz to obtain information about this claim from any third party is also an authorization for TD Life and/or TD Home & Auto to obtain copies of the information.
- I also authorize TD Life and/or TD Home & Auto, its reinsurers and its respective agents to exchange and/or transmit information concerning this claim to the organizations listed above as is necessary to evaluate this claim. This consent shall be valid during the continuation of such claim.
- I understand that if I am a dependent under this insurance coverage, the named insured will have access to information related to this claim in connection with the administration of this plan.
- I agree that a photocopy or facsimile of this authorization shall be valid as the original and that this authorization shall be considered valid for the duration of this claim, but not to exceed two years from the date it is signed. I understand information about me may be reviewed in the event that this plan is audited.
- I agree to provide all necessary assistance to secure the rights and remedies to subrogation of the claim against third parties who may be responsible for the claim.

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- I declare that all the statements made in this claim form are accurate, true and complete. I understand that making false, misleading or incomplete statements may cause not only the claim to be denied, but insurance coverage to be rescinded by TD Life and/or TD Home & Auto.

If I am not the Insured:
In providing this authorization to collect personal information about the Insured relating to this claim, I the undersigned do hereby certify that I have appropriate permission from the Insured to authorize the collection, use and disclosure of their personal information as authorized above and that the Insurer and its agents and reinsurers may rely and act upon my authorization.

Name of the Authorized Representative: _____
(Last Name) (First Name)

Address of the Authorized Representative: _____
(Number) (Street)

_____
(City) (Province) (Postal Code)

Signature of the Insured or Authorized Representative: _____ Date: _____
(Month, Day, Year)

Signature of Patient: _____ Date: _____
(If not the Insured) (Month, Day, Year)

Thank you for taking the time to complete this form.

For complete coverage information, please refer to your Certificate of Insurance. Assistance and Claims Services are provided by Allianz Global Assistance. Benefits are underwritten by TD Life Insurance Company and TD Home and Auto Insurance Company.

Section 7: Medical Information

Note: this section is only required if the cause of your claim is medical in nature.

Part 1: Patient's Information

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr.

Name: _____ Date of Birth: _____
(Last Name) (First Name) (Month, Day, Year)

Address: _____
(Number) (Street)

_____
(City) (Province) (Postal Code)

Patient's relationship to the Primary Cardholder/Certificate Holder: _____

Part 2: Attending Physician's Statement (Must be completed and signed by a licensed medical practitioner)

To Physicians – Please note

This form has been specifically designed with the Physician in mind. By being comprehensive, it will serve to reduce the physician's administrative workload. Please complete the sections relating to your patient.

The patient/Primary Cardholder/Certificate Holder is responsible for securing this form and any charge which may be made for its completion.

Date first seen by doctor: _____
(Month, Day, Year)

Diagnosis: _____

_____

_____

_____

_____

Is this a new condition? ❑ Yes ❑ No If no, what date was this condition first diagnosed: _____
(Month, Day, Year)

Date of first doctor visit for present onset: _____
(Month, Day, Year)

Has the patient received treatment or advice for this condition in the past year? ❑ Yes ❑ No

If yes, please provide all dates: _____
(Month, Day, Year)

Does the patient take ongoing medication for this condition? ❑ Yes ❑ No

If yes, please provide all names: _____

When was the medication last altered? _____ Why? _____
(Month, Day, Year)

If patient was referred to you, provide name and phone number of referring physician:

Were any follow up treatments required? ❑ Yes ❑ No If yes, please specify dates: _____ (Month, Day, Year)

Was the patient hospitalized? ❑ Yes ❑ No If yes, from _____ (Month, Day, Year) to _____ (Month, Day, Year)

Name of hospital: _____

If condition was due to pregnancy, please provide:

Date of confirmation of pregnancy: _____ (Month, Day, Year) Expected date of delivery: _____ (Month, Day, Year)

If patient was travelling, please complete:

Did you or the treating physician advise the patient to cancel his/her travel plans? ❑ Yes ❑ No

Patient was not fit to travel from _____ (Month, Day, Year) to _____ (Month, Day, Year)

(If patient is not travelling, please attach documentation indicating medical reason for cancellation)

Declaration:
These statements are true and complete to the best of my knowledge and belief.
I agree that I may be contacted for additional information regarding the above patient, including sending copies of medical records if needed.

Signature of Attending Physician: _____ Date: _____ (Month, Day, Year)

Registration Number: _____

Name of Attending Physician: _____ (Last Name) (First Name, Initial)

Address: _____ (Number) (Street)

_____ (City) (Province) (Postal Code)

Telephone Number: ( ) - Fax Number: ( ) -