gms

TRIP CANCELLATION & INTERRUPTION
Claim Form

Please complete this form, sign, attach all documents and submit to Group Medical Services, 2055 Albert Street PO BOX 1949 Regina, SK S4P 0E3.

If your trip was cancelled, provide the following documents:

- ❑ Proof of payment documents that include date of purchase, amounts of deposits, and final payment details
- ❑ Proof of cancellation
- ❑ Proof of the cause of cancellation
- ❑ Original booking confirmation with your itinerary
- ❑ Travel supplier's refund and change fee policy
- ❑ Copy of death certificate *(if applicable)*
- ❑ Written rental contract for the submitted expense *(if applicable)*

If your trip was interrupted, provide the following documents:

- ❑ Proof of travel dates
- ❑ Proof of payment for all submitted expenses
- ❑ Proof of claim with transportation carrier
- ❑ The police report *(if applicable)*

A. Policyholder Information

First Name	Last Name	Sex ❑ M ❑ F	Date of Birth *(DD/MM/YYYY)*

Address	City	Province	Postal Code

Phone ( )	Email	GMS Policy No.

B. Cancellation & Interruption Information

Your trip was: ❑ cancelled ❑ interrupted	The cause of cancellation or interruption occurred on what date *(DD/MM/YYYY)* ?

Describe the circumstances which resulted in the cancellation/interruption of your trip:

If you cancelled your trip due to the illness or death of a family member, what is your relationship:	Date Travel Supplier Notified *(DD/MM/YYYY)*

Total Amount Paid for Travel Arrangements	Amount Refunded From Any Source	Amount Claimed	Are you claiming loss: ❑ prior to departure ❑ after departure
$	$	$	

Signature of Claimant	Date *(DD/MM/YYYY)*
X	

C. Other Coverage Information

Please provide details of any additional insurance coverage relating to this claim *(attach additional information if necessary)*

Do you or your spouse have insurance through any other plan?
❑ Yes ❑ No *If "Yes" please complete the following.*

Type of Plan	Policy ID/Credit Card No.

Name of Bank/Credit Card/Insurance Company	Address

City	Province	Postal Code	Have you filed a claim? ❑ Yes ❑ No

D. Authorization to Physicians and Other Medical Providers and Insurance Companies

I/We declare the statements made herein are true and complete. I understand that any material misrepresentation or incorrect information will void my coverage. I authorize Group Medical Services to: (a) store and use any information which I have provided or information obtained pursuant to clause (b) for the purposes of administering this plan; and/or (b) for the purposes of determining my eligibility for benefits under this plan, to obtain information from, or provide information to: your provincial health plan; the operator of any hospital, clinic or other health care facility; a physician or other health care provider; any insurance company; or any other service provider as may be required.

Signature of Claimant **X**	Date *(DD/MM/YYYY)*

E. Physician's Statement

Patient First Name	Patient Last Name

Describe the nature of the injury or sickness:

When did the patient first consult you with this condition? *(DD/MM/YYYY)*	On what date was the patient diagnosed with this condition? *(DD/MM/YYYY)*

Date you last treated patient for this condition *(DD/MM/YYYY)*	Was the patient awaiting further investigation or treatment regarding this condition? ❑ Yes ❑ No

Please give the dates and treatment, including any medication prescribed and/or changed for this condition or related conditions within the last 6 months.

Are you the patient's regular physician? ❑ Yes ❑ No	Are you aware of any other physician who may have treated this patient for this or a similar condition? ❑ Yes ❑ No *If "Yes", please specify who* _____

Did the patient seek medical approval from you for this trip?
❑ Yes ❑ No *If "Yes", please provide a summary of advice given and the date of this consultation below.*

Is the condition due to pregnancy? ❑ Yes ❑ No *If "Yes", what is the expected date of delivery (DD/MM/YYYY)?* _____

Is the condition due to an accident? ❑ Yes ❑ No *If "Yes", what was the date of the accident (DD/MM/YYYY)?* _____

Was the patient hospitalized? ❑ Yes ❑ No *If "Yes", what was the date of admission (DD/MM/YYYY)* _____ *and discharge (DD/MM/YYYY)?* _____

Name of Hospital	Date traveller made you aware of his/her travel plans *(DD/MM/YYYY)*

In your medical opinion, what was the date the patient was assessed as unfit to travel *(DD/MM/YYYY)*

If this date differs from the date the condition was diagnosed, please explain why briefly below.

F. Physician Declaration

I certify that the information I have provided is correct and true to the best of my knowledge.

Physician's Signature **X**	Date *(DD/MM/YYYY)*

Full Name	Address	**Physician's Stamp**

City	Prov.	Postal Code	Phone ( )	Fax ( )