gms | Robin Assist

BAGGAGE LOSS, DAMAGE & DELAY
Claim Form

Please complete this form, sign, attach all documents and submit to Robin Assist, Attention: Imaging Center, 70 Talman Court, Concord ON, L4K 4L5.

Be sure to include the following documents:

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

A. Personal Information

First Name	Last Name	Date of Birth *(DD/MM/YYYY)*	
Home Address	City/Town	Province	Postal Code
Phone ( )	Policy Number		
Email	❑ Yes, I would like to receive emails about special offers, promotions and opportunities to provide feedback about GMS products and services.		

B. Trip Information

Departure Date *(DD/MM/YYYY)*	Return Date *(DD/MM/YYYY)*	Date of Loss or Damage *(DD/MM/YYYY)*
Location of Loss or Damage		
Who did you report the loss or damage to? (If you received a copy of the report, please include a copy with your claim.) ❑ Police ❑ Hotel Management ❑ Tour Guide ❑ Airline ❑ Other Transportation Authorities ❑ Other		
How did the damage or loss happen?		

C. Other Insurance Coverage (please provide details and attach additional information if necessary)

Do you have other insurance that may cover lost baggage or damage to your baggage? ❑ Yes ❑ No	Have you filed a claim? ❑ Yes ❑ No
Type of plan	Policy Number/Credit Card Number
Name and Address of Bank/Credit Card or Insurance Company	

D. Lost or Damaged Items

Attach the original receipt for each item and provide itemized receipts for replaced or repaired items.

Description of Item (state if item is part of a set)	Original Date of Purchase (DD/MM/YYYY)	Original Price Paid	Replacement Cost	Estimated Repair Cost
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
(To be completed by GMS Claims Department)		**TOTALS**	$	$
			PAYMENT	$

E. Declaration

GMS, its administrator, Robin Assist and their agents, are obliged to collect and retain certain personal and/or health information about you in connection with your insurance coverage. They use and disclose that information only for the purposes of administering your policy/policies of insurance, providing customer service, and assessing and paying claims.

- I/We authorize any licensed physician, medical practitioner, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, provincial health insurance plan and employer(s) to provide GMS, its administrator, Robin Assist and their agents engaged to assist in the administration of this claim, any information, including personal information, data, or records that are in their possession/knowledge, regarding my medical history and treatment.
- I/We direct and authorize my government health insurance plan (GHIP) to make payment in respect of my claim for out-of-country health services to the Insurer or its administrator Robin Assist directly and I hereby release the GHIP, upon payment to the Insurer from any further claim or cause of action in connection herewith.
- I/We hereby consent and authorize the GHIP to directly or indirectly collect information contained in the claim and source documents pursuant to the Freedom of Information and Protection of Privacy Act and the Health Information Protection Act.
- I/We authorize the Insurer and its administrator, Robin Assist, to coordinate the payment of benefits with any other insurance carriers which may also have a liability for this claim.
- I/We hereby irrevocably authorize the Insurer and its administrator, Robin Assist, to make any payments, receive payments, and settle with any carriers on my behalf.

I hereby consent to the collection, use and disclosure by the insurer, its agents and administrators of the personal and health information about me disclosed herein and in all documents or information provided in connection with my policy/policies of insurance for the purposes cited above.

If the undersigned is signing on behalf of any person(s), the undersigned represents to having the authority to sign on behalf of such person(s) and confirms that each of the above declarations and authorizations are also provided on behalf of such person(s).

A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from date signed.

Signature of all Claimants 18 years of age and older	Date (DD/MM/YYYY)
X	