gms | Robin Assist

TRIP CANCELLATION & INTERRUPTION
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.

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 w
- ❑ 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)*
Home Address	City/Town	Province	Postal Code
Phone ( )	Email		GMS Policy Number

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 X			Date (*DD/MM/YYYY*)

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

Type of plan		Policy ID/Credit Card No.	
Name of Bank/Credit Card/Insurance Company		Address	
City/Town	Province	Postal Code	Have you filed a claim? ❑ Yes ❑ No

D. 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*) date of 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.*	

E. 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*)	Physician's Stamp
Full Name		Address		
City	Province	Postal Code	Phone ( )	Fax ( )

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

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.

I agree that my electronic signature in this agreement has the same legal effect as handwritten signatures. Electronic signatures include any information in electronic form that a party has created or adopted in order to sign a document and that is in, attached to, or associated with the document, including signatures sent by fax or email.

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

For complete coverage information, please refer to your policy wording.

Travel assistance and claims administration services are provided by Robin Assist. Benefits are underwritten by Group Medical Services.