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CAA TRAVEL INSURANCE
BOUNCEBACK CLAIM FORM

PLEASE COMPLETE THE FOLLOWING QUESTIONS AND RETURN THIS FORM WITH THE REQUIRED DOCUMENTATION WITHIN 90 DAYS TO ENSURE PROMPT SETTLEMENT OF YOUR CLAIM.	POLICY No.

CASE #	CLAIM #	

1 CAA INSURED INFORMATION

Name:
Address:

Date:
Home Phone Number:
Work Phone Number:
E-mail:

2 CLAIM INSTRUCTIONS

1. COMPLETE BOTH SIDES OF THIS FORM IN FULL AND ATTACH ALL DOCUMENTS AS REQUESTED.
2. SIGN AND DATE COMPLETED FORM AND RETURN PACKAGE TO:

   CAA TRAVEL INSURANCE
   9TH FLOOR, 150 COMMERCE VALLEY DRIVE WEST
   THORNHILL, ONTARIO L3T 7Z3

   FOR CLAIMS INQUIRIES PLEASE CONTACT: 1-888-493-0161
   OR CALL COLLECT +1-905-532-2962

FAILURE TO COMPLETE THE CLAIM FORM AND ATTACH REQUESTED DOCUMENTS WILL DELAY THE PROCESSING OF YOUR CLAIM.

PLEASE ATTACH THE FOLLOWING DOCUMENTS:

- ◯ COPY OF AN ITEMIZED RECEIPT/INVOICE SHOWING THE COST OF YOUR 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 (SECTION 4 OF THIS FORM)
  OR DEATH CERTIFICATE (INDICATING CAUSE OF DEATH
  OR OTHER SUPPORTING DOCUMENTS TO SUBSTANTIATE YOUR CLAIM

PLEASE KEEP A COPY OF ALL THE SUBMITTED CORRESPONDENCE FOR YOUR RECORDS.

3 CLAIM DETAILS

YOUR CAA TRAVEL INSURANCE POLICY NUMBER

OTHER INSUREDS

NAME(S)	DATE OF BIRTH (DD/MM/YYYY)
1.	
2.	
3.	
4.	
5.	
6.	

NAME OF TRAVEL AGENCY		TELEPHONE NUMBER	
NAME OF AIRLINE/TOUR OPERATOR			
BOOKING DATE (DD/MM/YYYY)	SCHEDULED DEPARTURE DATE (DD/MM/YYYY)	SCHEDULED RETURN DATE (DD/MM/YYYY)	CANCELLATION DATE (DD/MM/YYYY)
COST OF TRIP $	AMOUNT OF PARTIAL REFUND $	TOTAL CLAIM $	
NAME OF ILL OR INJURED PERSON		RELATIONSHIP TO YOU	DATE OF BIRTH (DD/MM/YYYY)
NATURE OF SICKNESS OR INJURY			DATE INCIDENT OCCURRED (DD/MM/YYYY)
PLEASE SPECIFY REASON FOR TRIP INTERRUPTION			

COMPLETE REVERSE AND ATTACH ALL DOCUMENTS AS OUTLINED IN SECTION TWO

FOR COMPLETE COVERAGE INFORMATION, PLEASE REFER TO YOUR INSURANCE POLICY.

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4 MEDICAL CERTIFICATE (TO BE COMPLETED BY THE ATTENDING PHYSICIAN)

PATIENT NAME								
COMPLETE DIAGNOSIS:								
WAS THE PATIENT HOSPITALIZED? CHECK ONE ◯NO ◯YES	IF YES, FROM:	DD	MM	YYYY	TO:	DD	MM	YYYY
ON WHAT DATE DID THE PATIENT CONSULT YOU FOR THIS CONDITION?						DD	MM	YYYY
HAS THE PATIENT EVER HAD A SIMILAR CONDITION? CHECK ONE ◯NO ◯YES	IF YES, PROVIDE DATE:					DD	MM	YYYY
ON WHAT DATE WAS THE PATIENT FIRST DIAGNOSED?						DD	MM	YYYY
IF THE CONDITION WAS DUE TO AN ACCIDENT, WHAT WAS THE DATE OF THE ACCIDENT?						DD	MM	YYYY
IF THE CONDITION WAS DUE TO A PREGNANCY, WHAT WAS THE EXPECTED DATE OF DELIVERY?						DD	MM	YYYY
ADDITIONAL COMMENTS:								

NAME OF ATTENDING PHYSICIAN AND SPECIALTY		MEDICAL ID	ATTENDING PHYSICIAN STAMP
ADDRESS		CITY	
STATE/PROVINCE	POSTAL/ZIP CODE	COUNTRY	
TELEPHONE NUMBER	FAX NUMBER	EMAIL ADDRESS	

5 OTHER PHYSICIAN INFORMATION

NAME, ADDRESS AND TELEPHONE NUMBER OF ALL PHYSICIANS AND SPECIALISTS THAT THE ABOVE NAMED PATIENT HAS SEEN PRIOR TO THE BOOKING DATE OF THE TRIP.

NAME AND SPECIALTY	ADDRESS	TELEPHONE NUMBER
NAME AND SPECIALTY	ADDRESS	TELEPHONE NUMBER
NAME AND SPECIALTY	ADDRESS	TELEPHONE NUMBER

6 CERTIFICATION AND AUTHORIZATION

THE INSURER, ITS AGENTS AND ADMINISTRATORS ARE OBLIGED TO COLLECT AND RETAIN CERTAIN PROFESSIONAL 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 OF INSURANCE, PROVIDING CUSTOMER SERVICE AND ASSESSING AND PROCESSING CLAIMS.

I CERTIFY THAT THE INFORMATION I PROVIDE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS CLAIM SHALL BE VOID IF, WHETHER BEFORE OR AFTER THE LOSS, I CONCEALED OR MISREPRESENTED ANY FACTS, OR IF ANY DOCUMENTS RECEIVED REGARDING THIS CLAIM HAVE CONCEALED OR MISREPRESENTED ANY FACT OR CIRCUMSTANCES CONCERNING THIS CLAIM.

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.

INSURED (PRINT FULL NAME): _____

IF INSURED IS DEPENDENT PRINT FULL NAME OF PARENT OR GUARDIAN,
OR IF INSURED IS DECEASED PRINT FULL NAME OF EXECUTOR: _____

SIGNATURE: _____ **DATE:** _____

FOR COMPLETE COVERAGE INFORMATION, PLEASE REFER TO YOUR INSURANCE POLICY.