THE Great-West Life ASSURANCE COMPANY

TRIP CANCELLATION AND INTERRUPTION EXPENSES STATEMENT

*Please complete **all** sections of this form and mail to Great-West Life, Attention: Out-of-Country Claims Department PO Box 6000 Winnipeg MB R3C 3A5*

When submitting your claim be sure to include all of the following required documentation:

- Proof of originally scheduled trip (for example: trip itinerary, “e” or paper tickets).
- If applicable, proof of new scheduled trip (for example: trip itinerary, “e” or paper tickets).
- Itemized invoice(s) and proof of payment(s) for trip(s) and/or other claimed expenses.
- Statement from travel agent/ supplier indicating whether a refund and/or credit voucher has been issued. If no refund and/or credit is available, provide a copy of the cancellation terms and conditions indicating why one is not available.
- Any other supporting documentation showing the reason trip was cancelled/interrupted/extended, including a death certificate (if loss is due to death).
- If claiming medical expenses, complete the Out-of-Country claim form, along with the appropriate provincial authorization and assignment form located on www.greatwestlife.com.

Section A: Employee Information

Plan Number	I.D. Number	Plan Name

Last Name	First Name

Address	City	Province	Postal Code

Telephone Home	Telephone Work
( )	( )

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing you claim and administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life’s Chief Compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrator of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct and complete to the best of my knowledge.

Employee’s Signature: _____ Date: _____

Section B: Dependent Information (only complete if claim is being submitted on behalf of a dependent)

Dependent First Name	Last Name	Date of Birth

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Section C: Trip Details

Purpose of Trip	Destination
Scheduled Departure Date	Actual Departure Date (if applicable)
Scheduled Return Date	Actual Return Date (if applicable)

Section D: Type of Loss

Please indicate the general nature of the loss being claimed:

☐ Trip Cancellation ☐ Trip Interruption ☐ Trip Extension

Date trip was cancelled with the travel Agent/Supplier: _____

If the loss is due to sickness, please provide details of the illness: _____

Date symptoms first appeared: _____ Date of first medical consultation: _____

Date condition was diagnosed: _____

If loss is due to accident, please describe how the accident occurred: _____

Date of Accident: _____

If loss is due to death, please confirm the cause of death: _____

Date of Death: _____

If the loss is due to other circumstances, please provide details: _____

Date the loss first occurred: _____

Name of sick, injured or deceased person: _____

Your relationship to sick, injured or deceased person: _____

Name and address of sick, injured or deceased person's usual Family Physician:

Name: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Name and address of any other Physician who may have treated the sick, injured or deceased person in the last 12 months:

Name: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Section E: Statement of Expenses Claimed

Type of Expense Incurred	Date Incurred	Amount Paid	Currency	Amount Reimbursed by Travel Agent/Supplier

Section F: Statement of Other Coverage

Are you or any other member of your immediate family entitled to travel benefits under any other plan, including coverage through employment, individual/private plans or credit card plans that will cover or has covered a portion of this claim? ☐ Yes ☐ No

If 'Yes', please provide the following information:

Type of other coverage (group, individual, credit card)	Name and address of other coverage carrier	Phone Number	Policy or Plan Number	I.D. Number

Have you sent a claim and/or otherwise contacted the other carrier about this claim? ☐ Yes ☐ No

If 'Yes', please attach a copy of their settlement or denial.

If no, please provide explanation why: _____

Please sign the following statement if you have other insurance. This allows us to coordinate the payment of your claim with other insurance carriers. This statement must be signed before your claim can be assessed.

I _____ *hereby authorize Great-West Life and its agents to coordinate*
(Signature)
the payment of benefits with any other insurance carriers which may also have liability for this claim. I hereby irrevocably direct Great-West Life to make payments, receive payments and negotiate settlements with carriers on my behalf.

I further authorize Great-West Life to release and/or receive medical information from providers and other carriers for facilitate the payment and coordination of this claim.

Section G: Medical Certificate

This section is to be completed and signed by the licensed medical physician who treated the sick, injured or deceased person, resulting in this claim. Any fees for the completion of this form is the claimant's responsibility and are not covered by your Great-West Life plan.

Patient's First Name	Last Name		Date of Birth
Diagnosis/condition resulting in claim		Date symptoms first appeared	Date of first medical consultation
Date investigative/diagnostic testing began	Date condition was diagnosed	Date the patient was assessed as unfit to travel	
Date patient was advised not to travel		Has the patient suffered from this medical condition in the past? ☐ Yes ☐ No	

If 'Yes', please list below the patient's history of this condition and other related conditions:

Date of Consultation	Symptoms Exhibited/Diagnosis	Treatment Rendered

Section G: Medical Certificate *(continued)*

Was the condition related to alcohol, misuse of drugs, or self-inflicted injury? ☐ Yes ☐ No

If 'Yes', please provide details: _____

Was the condition related to pregnancy? ☐ Yes ☐ No

If 'Yes', please confirm the following details:

Date of Last Menstrual Period: _____ Expected Delivery Date: _____

Was the patient hospitalized? ☐ Yes ☐ No

If 'Yes', please confirm the following detail:

Name of Hospital: _____ Admission Date: _____ Discharge Date: _____

Are you the patient's usual family physician? ☐ Yes ☐ No

If 'No', please provide the name, address and telephone number for patient's usual family physician:

Name: _____ Phone #: ( ) _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Please also provide the name, address and telephone number of any other physician who treated the patient, or referred the patient to you:

Name: _____ Phone #: ( ) _____

Address: _____ City: _____ Province: _____ Postal Code: _____

I certify that the information provided in this section is complete, true and accurate to the best of my knowledge and belief.

Physician's Signature: _____ Date: _____

Physician's Name (please print): _____ Phone #: ( ) _____

Address: _____ City: _____ Province: _____ Postal Code: _____

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