



**PROCEDURE**

**POLICY NO.:** \_\_\_\_\_

You must cancel your trip with your service provider(s), i.e., the agency, wholesaler, Internet provider or airline company, and provide us with proof of cancellation. Please provide the following information:

Travel agency

Name \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_ Area code + number \_\_\_\_\_

Name of the agent \_\_\_\_\_ Telephone number \_\_\_\_\_

Wholesaler

Name \_\_\_\_\_ Address \_\_\_\_\_

Internet provider

Name \_\_\_\_\_ Web address \_\_\_\_\_

Airline company

Name \_\_\_\_\_

If you reserved a seat, cancel it and indicate the reimbursed amount \$ \_\_\_\_\_

Destination	Date you purchased your trip	Date of cancellation with the provider	Amount claimed	% of wholesaler's penalty	Are all the insureds under this policy cancelling their trip?
Travel dates from _____ to _____	Day Month Year	Day Month Year			<input type="checkbox"/> yes <input type="checkbox"/> no

**TO BE COMPLETED BY THE PRINCIPAL INSURED**

Name and address of any person for whom a claim is filed	Date of birth	Relationship to insured
	Day Month Year	
1- _____	_____	_____
2- _____	_____	_____
3- _____	_____	_____
4- _____	_____	_____

Reason for cancellation \_\_\_\_\_

Illness, injury (please specify): \_\_\_\_\_  Other (please specify): \_\_\_\_\_

Individual at the source of the cancellation: \_\_\_\_\_ Relationship to insured(s): \_\_\_\_\_

Name and address of physician consulted \_\_\_\_\_ Date of first consultation \_\_\_\_\_

\_\_\_\_\_ Postal code \_\_\_\_\_ Day Month Year \_\_\_\_\_

Have you submitted a claim to another insurance company?  yes  no

If yes, name of the insurance company \_\_\_\_\_ Policy number, identification number and/or file number \_\_\_\_\_

**DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION**

• All the information I have provided on the claim form is accurate and complete.

• I authorize Desjardins Financial Security Life Assurance Company, strictly for the purposes of determining my insurability, managing my file and settling my claims to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes **travel agencies, wholesalers, airline companies**, health care professionals or facilities, the MIB (formerly known as Medical Information Bureau), insurance companies, personal information officers or investigation agencies, the policyholder, my employer or former employers; (b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary, request an inquiry report about me, and also use the personal information it may have about me in existing files that are now closed. This authorization is also valid for the collection, use and communication of personal information concerning my minor children or \_\_\_\_\_

(Name of deceased) \_\_\_\_\_ insofar as applicable to the claim. A photocopy of this authorization is as valid as the original.

Signed at \_\_\_\_\_ on \_\_\_\_\_ 20\_\_\_\_\_

Signature of policyowner or legal heir \_\_\_\_\_

Signature of any insured who is not the policyowner \_\_\_\_\_

