



PROCEDURE

POLICY NO.: _____

You must cancel your trip with your service provider(s), i.e., the agency, the wholesaler, the Internet provider or the airline company. 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	Day Month Year	Day Month Year			<input type="checkbox"/> yes <input type="checkbox"/> no
from _____ to _____					

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 _____

I hereby certify that the information given is complete and true.

Signature of principal insured _____ Date _____

AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

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 _____

Any fees charge for this declaration are to be paid by the insured.

DECLARATION OF THE PHYSICIAN CONSULTED FOR THIS EVENT		OUR FILE NO.:	
Name of your patient	Age	Sex	
Diagnosis of the illness or nature of the injury			
With respect to the above-mentioned illnesses, conditions or injuries, prior to this medical event, did this person ever or was he/she ever:			
(a) receive medical treatment?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, specify over what periods.	
(b) take medication?	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	
(c) consult a physician?	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	
(d) hospitalized?	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	
(e) undergo surgery?	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	
(f) advised to do so?	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	
Was the patient's condition stable? ("Stable" means there has been no hospitalization or change in treatment or medication dosage. In the case of a diabetic, "dosage" is not a defining factor.) <input type="checkbox"/> yes <input type="checkbox"/> no			
If yes, since when? _____ Day _____ Month _____ Year _____			
If no, please specify _____			
Date of the accident or first symptoms	Date of the first consultation	Has the patient already suffered from the same illness before?	If yes, indicate when and explain
Day _____ Month _____ Year _____	Day _____ Month _____ Year _____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
Was this patient referred to you by another doctor?		If yes, specify his/her name: _____	
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> the patient is not the traveller		His/her address: _____	
		Date on which this doctor referred this patient to you: _____	
Was the patient unable to travel because of the illness or injury?		If yes, indicate the date on which you recommended the trip be cancelled: _____	
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> the patient is not the traveller		If yes, indicate the duration of the incapacity to travel	
		From _____ to _____	
Is the illness or injury the only reason for the patient's incapacity to travel?		If not, what are the other reasons?	
<input type="checkbox"/> yes <input type="checkbox"/> no		_____	
IDENTIFICATION OF THE PHYSICIAN			
Name and address of the physician (BLOCK LETTERS)			

_____	Postal code	_____	Telephone number
_____	_____	_____	Area code + Number
_____	_____	_____	_____
Signature of the physician	Date	Specialty	

Thank you for your cooperation