Group Medical Services

Trip Cancellation & Interruption
Claim Form

Instructions
Please complete all sections and submit to: **Group Medical Services** 2055 Albert Street PO Box 1949, Regina, SK S4P 0E3

A. Personal Information

First Name _____ Last Name _____ Date of Birth DD / MM / YYYY

Address _____ City _____ Province _____ Postal Code _____

Home Tel (_____) _____ Email _____ GMS Policy # _____

B. Cancellation & Interruption Claims

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, please state your relationship _____

Date of the Cause of the Cancellation DD / MM / YYYY OR, Date of the Interruption DD / MM / YYYY

Date Travel Supplier Notified DD / MM / YYYY

Total Amount Paid for Travel Arrangements: $ _____ Amount Refunded From any Source: $ _____

Amount Being Claimed: $ _____ Are you claiming loss: ❑ prior to departure ❑ after departure

Claimant's Signature X _____ **Date** DD / MM / YYYY

C. Other Insurance Coverage

Please provide details of any additional insurance coverage relating to this claim (attach additional information if necessary).

Do you or your spouse have benefits through any other plan? ❑ Yes ❑ No If yes, complete the following:

Type of Plan _____ Policy/ID/Credit Card # _____

Name and Address of Bank/ Credit Card or Insurance Company _____

Have you filed a claim? ❑ Yes ❑ No

D. Authorization to Physicians and other Medical Providers and Insurance Companies

I/We declare the statements made herein are true and complete. I understand that any material misrepresentation or incorrect information will void my coverage. I authorize Group Medical Services to: (a) store and use any information which I have provided or information obtained pursuant to clause (b) for the purposes of administering this plan; and/or (b) for the purposes of determining my eligibility for benefits under this plan, to obtain information from, or provide information to: your provincial health plan; the operator of any hospital, clinic or other health care facility; a physician or other health care provider; any insurance company; or any other service provider as may be required.

Signature of Claimant X _____

Name of Claimant _____ (Please Print) **Date** DD / MM / YYYY

PLEASE COMPLETE SCHEDULE OF ITEMS ON REVERSE AND RETURN FORM TO GMS

E. Treating Physician's Statement

Name of Patient _____

Nature of 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 prior to travelling: DD / MM / YYYY

Was the patient awaiting further investigation or treatment regarding this condition? ❑ Yes ❑ No

Give dates and list 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, give a summary of advice given and the date of this consultation:

Is condition due to pregnancy? ❑ Yes ❑ No If yes, what is the expected date of delivery? DD / MM / YYYY

Is condition due to an accident? ❑ Yes ❑ No If yes, what was the date of the accident? DD / MM / YYYY

Was patient hospitalized? ❑ Yes ❑ No If yes, what was the date of admission DD / MM / YYYY and discharge? DD / MM / YYYY

Name of Hospital _____

Date Traveller Made You Aware of His/Her Travel Plans DD / MM / YYYY

In your medical opinion, give the date patient was assessed as unfit to travel DD / MM / YYYY

If above date differs from the date the condition was diagnosed, please explain briefly:

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

Complete Name and Address _____

_____

Phone Number ( ) _____ Fax Number ( ) _____

Physician's Stamp