JF Canadian Travel Insurance
Baggage Benefit Claim Form

Ontime Care Worldwide Inc.
P.O.Box 82029, 420 Hwy 7 E,
Richmond Hill, ON, L4B 3K2, Canada
Toll free Canada/US 1-888-988-3268
Collect Worldwide 905-707-9555

Instruction

Important

- All claims must be reported to OTC within 30 days of occurrence. Written proof of claim must be submitted to OTC within 90 days of occurrence.

- You are responsible for all fees charged for completion of this form and any supporting documentation.

Claims Submission

*To complete the claim submission, please complete the claim form, signed and dated.
*Detailed list of stolen or damaged items or, in case of delayed baggage, a list of necessary toiletries and clothing
*Proof of ownership of lost/damaged/stolen or delayed item: receipts, credit card statement, photos, etc.
*A letter detailing your version of events and circumstances leading to the claim
*A baggage irregularity report for list, damaged, stolen, or delayed items: be filed with the airline, airport, cruise line, bus line, tour operator, hotel etc. Policy or other competent authority's report regarding the theft. Claims without this report will not be considered.
*Electronic airline tickets and labels confirming baggage check
*Purchase receipts for stolen or damaged items or purchase receipts for necessary toiletries and clothing in case of delayed baggage
*Letter of settlement or denial of the airline company
*Please use **Canada Post** to send the claim file and be sure to keep a copy of your claim for your records.

If you can't submit all requested documents, please provide us with an explanation in a letter attached to your claim. We reserve the right to request original documents or additional information if needed. Please keep a copy of your supporting documents for your records.

SECTION A: INSURED'S INFORMATION

Insured's First Name:____________________ Last Name:____________________

☐ Male ☐ Female Date of Birth (MM/DD/YY):__________ Policy #:____________________

Address in Canada

Street Address:____________________

City/Town:__________ Province:__________ Postal Code:____________________

Telephone:__________ Email address:____________________

Date of Departure:____________________ Date of Return to home province:__________

Destination:____________________

Do you have other travel medical insurance coverage? ☐ Yes ☐ No If 'Yes', please provide the following information:

Name of Insurance Company:____________________

Policy #:__________ Member ID:__________ Telephone:__________

Do you have insurance coverage through your spouse? ☐ Yes ☐ No If 'Yes', please provide the following information:

Name of Insurance Company:

Policy #:__________ Member ID:__________ Telephone:__________

Spouse's Name:____________________ Spouse's Date of Birth:__________

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Do you have credit card insurance coverage? ☐ Yes ☐ No If 'Yes', please provide the following information:

Name of the financial Institution:______________________________

First 6 digits of credit card: ______________________ Expiry Date(MM/YYYY): ______________________

Name of Cardholder(Please print):______________________ Cardholder Signature: ______________________

Do you have insurance benefits available through group insurance or any other source?

☐ Yes ☐ No If 'Yes', provide details below.

Group Insurance

Name and Address of Insurance Company:______________________________

Policy Number:______________________ Telphone#:______________________

Other Travel Insurance

Name and Address of Insurance Company:______________________________

Policy Number:______________________ Telphone#:______________________

SECTION B: TYPE OF LOSS

☐ Lost ☐ Theft ☐ Damage ☐ Delay

Describe how and where the loss occured:______________________________
____
____

Date loss occured:______________________ To whom was loss reported?: ______________________

☐ Airline ☐ Cruise line ☐ Bus line ☐ Tour Guide ☐ Hotel ☐ Police

☐ Other(please specify)______________________________

SECTION C: SCHEDULE OF ITEMS LOST, DAMAGED, STOLEN OR DELAYED

Please use the section C table attached

SECTION D: AUTHORIZATION AND CERTIFICATION

I authorize any other insurer to release and exchange with Ontime Care Worldwide or its representatives any information that the insurer requires to process this claim. I assign to Ontime Care Worldwide any benefits payable from any other sources for losses covered under this policy and I authorize and direct such payors to forward payment directly to Ontime Care Worldwide. I also authorize any third party providing me with assistance in this claims process, to have access to any and all relevant claims information related to the adjudication of my claim with Ontime Care Worldwide. I confirm I am authorized to act on behalf of my dependants for these purposes. A photocopy of this authorization shall be as valid as the original. I certify that the information provided in connection with this claim is complete, true and accurate.

Full Name of Insured (please print):______________________ Date:______________________

I authorize payment of this claim to (print name):______________________________

Insured's Signature (if minor, signature of parent or legal guardian):______________________________

Signature of policyholder of other insurance specified in Section A (if applicable):______________________________

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SECTION C: SCHEDULE OF ITEMS LOST, DAMAGED, STOLEN OR DELAYED

Description of Item Claimed	Quantity	Owner of the Item	Date Purchased	Purchased Price (CAD)	Estimated Repair Cost or Actual Value

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