How to Submit a Claim

Trip Cancellation

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.

To Submit Your Claim

Gather all your claim documentation

- Trip itinerary © of itemized invoice showing amount paid for your trip
- Proof of payment for your trip
- Statement from your travel supplier indicating whether a refund and/ or credit voucher has been issued or, if no refund and/or credit is available, a copy of the Cancellation Terms and Conditions on the booking(s)
- Medical record from physician if your trip was cancelled for medical reasons.
- Other supporting documents showing non-medical reasons for cancelling your trip
- Explanation of benefits of your credit card insurance
- All the hotels, transportation, and meals invoices and receipts that are eligible to claim

Complete and sign the claim form

Mail all documentation to Ontime Care World Wide Inc.

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.

SUBMIT YOUR CLAIM

Send you completed forms and original receipts to:

P.O.Box 82029, 420 Hwy 7 E,
Richmond Hill, ON, L4B 3K2,
Canada

To check your claim status, please call:

Toll free Worldwide :1-877-832-5541
Canada: 1-905-707-1512

How to Submit a Claim

Trip Interruption

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.

To Submit Your Claim

Gather all your claim documentation

- Your original trip itinerary(tickets) & copy of itemized invoice showing amount originally paid for your trip
- Your new trip itinerary(tickets) & copy of itemized invoice showing amount originally paid for your trip
- Proof of payment for your trip
- Original receipt
- Other supporting documents showing non-medical reasons for cancelling your trip

Complete and sign the claim form

Mail all documentation to Ontime Care World Wide Inc.

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.

SUBMIT YOUR CLAIM

Send you completed forms and original receipts to:

P.O.Box 82029, 420 Hwy 7 E,
Richmond Hill, ON, L4B 3K2,
Canada

To check your claim status, please call:

Toll free Worldwide :1-877-832-5541
Canada: 1-905-707-1512

JF Canadian Travel Insurance
Trip Cancellation and Interruption 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

SECTION A: INSURED'S INFORMATION

Insured's First Name:______________________________ Last Name: ______________________________

☐ Male ☐ Female Date of Birth (MM/DD/YY):______________ Policy #: ______________________________

Second Insured's First Name:______________________________ Last Name: ______________________________

☐ Male ☐ Female Date of Birth (MM/DD/YY):______________ Policy #: ______________________________

Address in Canada

Street Address:____

Province:__________________ Postal Code:______________ Destination:______________________________

Telephone:__________________ Fax:__________________ Email address:______________________________

Scheduled Departure Date:______________________________ Scheduled Return Date:______________________________

SECTION B: TYPE OF LOSS

Please indicate the general nature of the loss being claimed for: ☐ Trip Cancellation ☐ Trip Interruption ☐ Delays

If loss is due to **sickness**, please provide details:____

Date symptoms or injury first appeared:__________________ Date you first saw physician for this condition:__________________

If loss is due to **injury**, please provide details:____

Describe how the injury/accident occured:____

____ Date of injury/accident:______________________________

If loss is due to **death**, please provide details:____

Date of death:______________ Cause of death:____

Your relationship to sick, injured or deceased person:______________ Name of patient or deceased:______________________

Name and Address of patient's usual Family Physician

Name:____

Address:____

City:______________________________ Province:______________________ Postal Code:______________________________

Name and Address of any other physician who may have treated the patient in the last 12 months

Name:____

Address:____

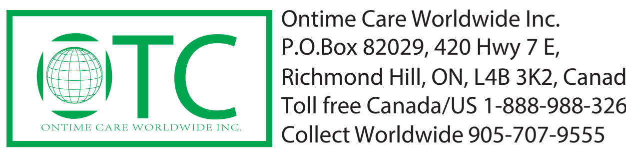
City:______________________________ Province:______________________ Postal Code:______________________________

If **loss** is due to **other circumstances**, please provide description of loss:______________________________

____

Date the loss first occured:______________________ Date you cancelled with travel agent/travel supplier:______________________

JF Canadian Travel Insurance
Trip Cancellation and Interruption 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

SECTION C: EXPENSES CLAIMED

Please use the section C table attached

SECTION D: OTHER INSURANCE COVERAGE

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#:____________________

Have you claimed from any other party?

☐ Yes ☐ No If 'Yes', please attach a copy of their settlement or denial.

If the loss was not reported, please provide explanation:____

Insured's signature:____________________ Date:____________________

SECTION E: AUTHORIZATION AND CERTIFICATION

I authorize any doctor, hospital or facility providing medical or health-related services, and any other insurer to release and exchange with Ontime Care Worldwide or its representatives, any information that is required 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):____

I authorize (insured's name):____

to have access to any and all relevant claims information, including medical records, related to the adjudication of this claim.

Signature of Patient:____________________ 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 D (if applicable):____

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

SECTION C: EXPENSES CLAIMED

Type of Expense Incurred *(airline ticket, hotel, etc.)*	Date Incurred	Amount Paid	Currency	Amount Reimbursed/Refunded *by Travel Agent or Supplier*