

Section 1: To be completed by Claimant/Insured

About the Claimant/Insured

Name of Claimant/Insured		Claim Number
Address (street, city, province, postal code)		
Date of Birth	Trip Departure Date	Policy Date

About the Patient

Name of Patient		Date of Birth
Was Patient travelling with Claimant?	Yes No	Relationship of Patient to Claimant (if not the Claimant/Insured)

Authorization to Disclose Information

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I, (the "Patient"), authorize the release of any medical information about me to Arch Insurance Canada, Ltd., (the "Company"); or it's authorized representative. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past.

The Company will use this information to determine if any claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigation or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization.

I certify that the information given by me in support of my claim is true and correct. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution or insurance fraud.

Patient's or Authorized Representative's Signature	If Authorized Representative, Relationship to Patient or Legal Designation	Date
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Section 2: To be completed by physician

About the Diagnosis and Treatment

Diagnosis / ICD Code (primary diagnosis)	
Diagnosis / ICD Code (secondary diagnosis)	
What are the Patient's symptoms?	Date symptoms first appeared?
Date Patient first consulted you for this condition?	Date of positive covid test, if applicable?
Has the Patient ever had this condition before? Yes No	If yes, prior dates of treatment?
Is this condition an exacerbation or a complication of an existing condition? Yes No	If yes, when did the condition worsen?
If the Patient was referred from or to another physician, name and phone number of that physician?	
Dates of medical visits as they relate to the condition causing the trip cancellation/interruption. Date(s) of visit?	Was the Patient seen for a physical exam? Yes No
Is the Patient hospitalized or have they been in the past 12 months for this condition or related conditions?	Yes No
If yes, Name & Location of Hospital?	
Dates of Hospitalization?	

Section 2, continued: To be completed by physician

About the Medical Condition as it relates to Travel

On what date was the Patient disabled and unable to travel?	
Explain in detail reasons for restrictions that would prevent the Patient's travel on date of departure.	
How long will the Patient be unable to travel?	
If the Patient was the non-traveller, did you advise the Claimant/Insured to cancel or interrupt the trip due to the non-traveller's medical condition? Yes No	
If yes, please explain:	If no, on what date was it reasonable for the Claimant/Insured to cancel/interrupt their trip?
Date you advised traveller to cancel trip:	

Physician Information and Signature

Please note: All of the above requested information is necessary for the processing of the Claimant's claim. Any omitted items will delay processing.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable by law.

I have read the foregoing, and the above answers are true and complete according to the best of my knowledge and belief.

Physician's Signature		Date
Physician's Name		
License Number	Specialty	
Phone Number	Fax Number	
Affiliated Medical Facility Information, if applicable Facility Name & Location		



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