ZURICH GROUP ACCIDENT AND BUSINESS TRAVEL INSURANCE
ACCIDENTAL DEATH & DISMEMBERMENT CLAIM FORM

ZURICH®

1 POLICY HOLDER INFORMATION

CLAIM #	
NAME OF POLICY HOLDER:	**DATE:**
CLAIMANT NAME:	**HOME PHONE:**
ADDRESS:	**MOBILE PHONE:**
CITY, POSTAL CODE:	**EMAIL:**

2 CLAIM INSTRUCTIONS

- VERIFY THAT THE ABOVE INFORMATION IS ACCURATE AND MAKE CHANGES WHERE REQUIRED.
- COMPLETE THIS FORM IN FULL AND ATTACH ALL DOCUMENTS AS REQUESTED.
- SIGN AND DATE COMPLETED FORM AND RETURN PACKAGE TO:
  TRAVELCLAIMS@WTP.CA
  OR
  ZURICH TRAVEL ASSIST
  SUITE 5350, 100 KING STREET WEST
  TORONTO, ON
  M5X 1C9
  CANADA

FOR CLAIMS INQUIRIES, PLEASE CONTACT: 1 (416) 649 2555
OR 1 (877) 541 0127.

FAILURE TO COMPLETE THE CLAIM FORM AND ATTACH REQUESTED DOCUMENTS WILL DELAY THE PROCESSING OF YOUR CLAIM.

PLEASE ATTACH THE FOLLOWING DOCUMENTS:

- COMPLETED CLAIM FORM
- CERTIFIED TRUE COPY OF DEATH CERTIFICATE (ACCIDENTAL DEATH CLAIM)
- POLICE REPORT (IF APPLICABLE)
- AUTOPSY/POSTMORTEM & TOXICOLOGY REPORT (IF APPLICABLE)
- ALL RELEVANT MEDICAL REPORTS TO SUPPORT CLAIM

IF THE CLAIM PROCEEDS ARE PAYABLE TO AN ESTATE, THE FORM MUST BE COMPLETED BY THE EXECUTOR OR ADMINISTRATOR OF THE ESTATE. DOCUMENT APPOINTING THE EXECUTOR OR ADMINISTRATOR MUST BE ATTACHED TO THIS FORM

IF ANY DESIGNATED BENEFICIARY IS A MINOR, THE FORM MUST BE COMPLETED BY A CUSTODIAN OR GUARDIAN.

PLEASE KEEP A COPY OF ALL THE SUBMITTED CORRESPONDENCE FOR YOUR RECORDS.

WHAT TO EXPECT DURING THE CLAIMS PROCESS

IT IS OUR GOAL TO PROCESS ELIGIBLE CLAIMS IN A PROMPT MANNER, HOWEVER PROCESSING MAY BE DELAYED FOR THE FOLLOWING REASONS:

- DELAY IN RECEIPT OF MAIL FROM PROVIDERS
- DELAY IN RECEIPT OF MEDICAL INFORMATION FROM YOUR TREATING OR FAMILY PHYSICIAN
- INCOMPLETE CLAIM FORM AND/OR INSUFFICIENT SUPPORTING DOCUMENTATION

IN ORDER TO EXPEDITE YOUR CLAIM, PLEASE RETURN THE COMPLETED CLAIM FORM AND ALL SUPPORTING DOCUMENTS AS SOON AS POSSIBLE AND KEEP A COPY FOR YOUR RECORDS.

3 INSURED DETAILS

NAME OF EMPLOYER	ADDRESS OF EMPLOYER
NAME OF DECEASED OR INJURED PERSON	DATE OF BIRTH (DD/MM/YYYY)
DEPARTURE DATE (DD/MM/YYYY)	RETURN DATE (DD/MM/YYYY)

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RE: **CLAIM #**

4 CLAIM DETAILS

COUNTRY WHERE ACCIDENT OCCURRED	DATE OF ACCIDENT (DD/MM/YYYY)
DESCRIBE HOW ACCIDENT OCCURRED	
DID ACCIDENT RESULT IN DEATH? ☐ YES ☐ NO	IF YES, ON WHAT DATE?
WAS AUTOPSY PERFORMED? ☐ YES ☐ NO	IF YES, PLEASE PROVIDE CORONER'S CONTACT INFORMATION BELOW

NAME OF CORONER	ADDRESS	TELEPHONE NUMBER

NAME, ADDRESS AND TELEPHONE NUMBER OF ALL PHYSICIANS AND SPECIALISTS THAT THE CLAIMANT HAS SEEN PRIOR TO THE DEPARTURE DATE

NAME AND SPECIALTY	ADDRESS	TELEPHONE NUMBER
NAME AND SPECIALTY	ADDRESS	TELEPHONE NUMBER
NAME OF BENEFICIARY	ADDRESS	TELEPHONE NUMBER

5 MEDICAL CERTIFICATE (TO BE COMPLETED BY THE ATTENDING PHYSICIAN)

PATIENT'S NAME	DATE OF BIRTH (DD/MM/YYYY)
WHEN DID ACCIDENT HAPPEN (DD/MM/YYYY)	WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? (DD/MM/YYYY)
NATURE OF INJURY: PLEASE EXPLAIN IN COMPLETE DETAIL, INCLUDING ALL DIAGNOSES, ANY DISMEMBERMENT OR LOSS OF USE; THE CAUSE OR INCIDENT CAUSING THE INJURY, AND ALL EFFECTED BODY PARTS.	
IF INJURY RESULTED IN SEVERANCE OF A BODY PART, PLEASE INDICATE THE PRECISE LOCATION OF THE SEVERANCE:	
DID INJURY RESULT IN THE TOTAL AND IRRECOVERABLE LOSS OF HEARING IN BOTH EARS? ☐ YES ☐ NO	DATE OF LOSS (DD/MM/YYYY):

DID THE INJURY RESULT IN LOSS OF SIGHT, WAS THE LOSS TOTAL AND IRRECOVERABLE? ☐ YES ☐ NO	WHICH EYE WAS INJURED? ☐ ☐	WAS EYE REMOVED? ☐ YES ☐ NO

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5 MEDICAL CERTIFICATE (TO BE COMPLETED BY THE ATTENDING PHYSICIAN) (CONTINUED)

WAS THE PATIENT CONFINED TO A HOSPITAL? ☐ YES ☐ NO	IF YES, PROVIDE DATES OF CONFINEMENT	
NAME OF HOSPITAL OF CONFINEMENT	ADDRESS	
IS THE PATIENT STILL UNDER YOUR CARE? ☐ YES ☐ NO	IF DISCHARGED, GIVE DATE OF DISCHARGE (DD/MM/YYYY):	
SIGNATURE OF ATTENDING PHYSICIAN	PHYSICIAN'S NAME (PLEASE PRINT)	
ADDRESS	TELEPHONE	DATE

6 CERTIFICATION AND AUTHORIZATION

ZURICH INSURANCE COMPANY LTD (CANADIAN BRANCH), ITS AGENTS AND AUTHORIZED ADMINISTRATORS (HEREINAFTER "THE INSURER", OR "THEY") ARE OBLIGED TO COLLECT AND RETAIN CERTAIN PERSONAL AND/OR HEALTH INFORMATION ABOUT YOU IN CONNECTION WITH YOUR INSURANCE COVERAGE. THEY USE AND DISCLOSE THAT INFORMATION ONLY FOR THE PURPOSES OF ADMINISTERING YOUR POLICY OF INSURANCE, PROVIDING CUSTOMER SERVICE AND ASSESSING AND PAYING CLAIMS.

I/WE AUTHORIZE ANY LICENSED PHYSICIAN, MEDICAL PRACTITIONER, HOSPITAL, CLINIC, OTHER MEDICAL FACILITY OR PROVIDER OF HEALTH CARE, INSURER OR REINSURER, PROVINCIAL HEALTH INSURANCE PLANAND EMPLOYER(S) TO PROVIDE WORLD TRAVEL PROTECTION CANADA INC., AND ITS REPRESENTATIVES EMPLOYED TO ASSIST IN THE ADMINISTRATION OF THIS CLAIM, ANY INFORMATION, INCLUDING PERSONAL INFORMATION, DATA OR RECORDS THAT ARE IN THEIR POSSESSION/KNOWLEDGE REGARDING MY MEDICAL HISTORY AND TREATMENT.

IN CONSIDERATION OF PAYMENT MADE ON MY BEHALF, I AUTHORIZE ANY BENEFITS PAID OR PAYABLE BY ANY OTHER INSURANCE CARRIER, IN RESPECT TO THIS CLAIM TO BE ASSIGNED IN WHOLE OR IN PART TO WORLD TRAVEL PROTECTION CANADA INC., FOR THE BENEFIT OF THE INSURANCE COMPANY UNDERWRITING THE POLICY FOR WHICH SUCH PAYMENT IS MADE.

SPECIAL GHIP DIRECTION (IF THE CLAIMANT IS A CHILD, THIS SECTION APPLIES TO A PARENT OR LEGAL GUARDIAN).

I/WE DIRECT AND AUTHORIZE MY GOVERNMENT HEALTH INSURANCE PLAN (GHIP) TO MAKE PAYMENT IN RESPECT OF MY CLAIM FOR OUT-OF-COUNTRY HEALTH SERVICES TO **WORLD TRAVEL PROTECTION CANADA INC.** DIRECTLY, AND I RELEASE GHIP, UPON PAYMENT TO WORLD TRAVEL PROTECTION, FROM ANY FURTHER CLAIM OR CAUSEOF ACTION IN CONNECTION HEREWITH.

I CONSENT TO THE DISCLOSURE BY GHIP TO WORLD TRAVEL PROTECTION OF SUCH PERSONAL INFORMATION AS MAY BE NECESSARILY REQUIRED FOR PROCESSING OF MY CLAIM, INCLUDING DETAILS OF ANY DUPLICATE PAYMENT PREVIOUSLY MADE DIRECTLY TO ME.

I CONSENT AND AUTHORIZE GHIP TO DIRECTLY OR INDIRECTLY COLLECT INFORMATION CONTAINED IN THE CLAIM AND SOURCE DOCUMENTS PURSUANT TO SECTION 39(1) OF THE FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT, AND TO SECTION 4(2)(F) OF THE HEALTH INSURANCE ACT.

FOR ONTARIO RESIDENTS ONLY : I ACKNOWLEDGE THAT THE INFORMATION COLLECTED AND USED BY OHIP ON THIS FORM AND RELATED TO ANY CLAIMS FOR WHICH I AM ENTITLED TO PAYMENT BY OHIP IS COLLECTED FOR THE PURPOSES OF ASSESSING MY CLAIM, PROCESSING PAYMENT THEREFORE AND ANY RELATED PURPOSES IN ACCORDANCE WITH SECTION 4.1(1) AND 1.1(2) OF THE HEALTH INSURANCE ACT.

I/WE AUTHORIZE WORLD TRAVEL PROTECTION, TO COORDINATE THE PAYMENT OF BENEFITS WITH ANY OTHER INSURANCE CARRIERS WHICH MAY ALSO HAVE A LIABILITY FOR THIS CLAIM. I/WE HEREBY IRREVOCABLY DIRECT WORLD TRAVEL PROTECTION, TO MAKE ANY PAYMENTS, RECEIVE PAYMENTS AND SETTLE WITH OTHER CARRIERS ON MY BEHALF.

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RE: **CLAIM #**

6 CERTIFICATION AND AUTHORIZATION (CONTINUED)

PERSONAL INFORMATION NOTICE

I UNDERSTAND THAT THE INFORMATION PROVIDED BY ME ON THIS CLAIM FORM AND OTHERWISE IN RESPECT OF MY CLAIM, IS REQUIRED BY THE INSURER, ITS REINSURERS TO ASSESS MY ENTITLEMENT TO BENEFITS, INCLUDING BUT NOT LIMITED TO DETERMINING IF COVERAGE IS IN EFFECT, INVESTIGATING THE APPLICABILITY OF EXCLUSIONS. FOR THESE PURPOSES, THE INSURER WILL ALSO CONSULT ITS EXISTING INSURANCE FILES ABOUT ME, COLLECT ADDITIONAL INFORMATION ABOUT AND FROM ME, AND WHERE REQUIRED, COLLECT INFORMATION FROM AND EXCHANGE INFORMATION WITH THIRD PARTIES.

PRIVACY CONSENT NOTICE

BY SUBMITTING THE REQUESTED INFORMATION, WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, NAME, ADDRESS, DATE OF BIRTH, DRIVER'S LICENCE NUMBER, MEDICAL INFORMATION, FINANCIAL INFORMATION, AND DRIVING RECORD, AUTOMOBILE INSURANCE POLICY HISTORY, OR AUTOMOBILE INSURANCE CLAIMS HISTORY, YOU ARE PROVIDING CONSENT TO ZURICH INSURANCE COMPANY LTD AND ITS SUBSIDIARIES AND AFFILIATES LOCATED IN YOUR COUNTRY OF RESIDENCY OR ABROAD (COLLECTIVELY, "ZURICH") FOR THE COLLECTION, STORAGE, USE, DISCLOSURE AND PROCESSING OF YOUR PERSONAL INFORMATION AS MAY BE NECESSARY TO ASSESS, INVESTIGATE, ADMINISTER, ADJUST, AND SETTLE CLAIMS (INCLUDING REINSURANCE CLAIMS), COORDINATE AND CONSULT THIRD PARTY SPECIALISTS AND EXPERTS, PREVENT, DETECT AND SUPPRESS FRAUD, SUPPORT CUSTOMER SERVICE IMPROVEMENT AND COMPLAINT HANDLING, FOR STATISTICAL EVALUATION, OR TO MEET REGULATORY OR OTHER OPERATIONAL REQUIREMENTS. YOU ARE ALSO PROVIDING CONSENT TO ZURICH FOR THE DISCLOSURE OF YOUR PERSONAL INFORMATION TO THIRD PARTIES, AS REQUIRED FOR AND IN RELATION TO ONE OR MORE OF THE ABOVE-STATED PURPOSES, INCLUDING REINSURERS, THIRD PARTY ADMINISTRATORS, BROKERS, AGENTS, CLAIMS ADJUSTERS, APPRAISERS, HEALTHCARE CLINICS, PHYSICIANS, LAWYERS, AUDITORS, ENGINEERS, ARCHITECTS, ACCOUNTANTS, AUTOBODY SHOPS, TOW TRUCK COMPANIES, RESTORATION CONTRACTORS, REGULATORS OR OTHER GOVERNMENTAL OR PUBLIC BODIES, TAXING AUTHORITIES, INDUSTRY ASSOCIATIONS, THE INSURED IN THE EVENT OF A THIRD PARTY LOSS, OTHER INSURERS, AND OTHER THIRD PARTIES INVOLVED IN PROVIDING INSURANCE SERVICES (COLLECTIVELY, "THIRD PARTIES"). IF YOUR POLICY WAS ARRANGED FOR BY A BROKER OR AN AGENT, YOU AUTHORIZE ZURICH TO COLLECT, STORE, USE, DISCLOSE, AND PROCESS PERSONAL INFORMATION RECEIVED FROM SUCH BROKER OR AGENT IN RELATION TO THE ABOVE-STATED PURPOSES. ADDITIONALLY, BY PROVIDING INFORMATION ABOUT A THIRD PARTY, INCLUDING BUT NOT LIMITED TO, A FAMILY MEMBER, DIRECTOR, OFFICER, EMPLOYEE, OTHER NAMED INSURED, LISTED DRIVER, OR ANY PARTY THAT HAS AN INTEREST IN OR DERIVES A BENEFIT FROM THE POLICY, YOU HEREBY COVENANT AND WARRANT THAT YOU HAVE OBTAINED THE APPROPRIATE CONSENT FROM SUCH THIRD PARTY TO DISCLOSE THEIR PERSONAL INFORMATION TO ZURICH AND FOR ZURICH TO USE AND DISCLOSE SUCH INFORMATION FOR ANY OF THE ABOVE-STATED PURPOSES.

ZURICH IS COMMITTED TO PROTECTING THE PRIVACY AND CONFIDENTIALITY OF INFORMATION PROVIDED. YOUR PERSONAL INFORMATION MAY BE PROCESSED BY AND IS SECURELY STORED WITHIN THE OFFICES OF ZURICH AND AUTHORIZED THIRD PARTIES, BOTH IN DOMESTIC AND FOREIGN JURISDICTIONS OUTSIDE CANADA AND IS SUBJECT TO APPLICABLE LAWS.

ZURICH MAY RETAIN YOUR PERSONAL INFORMATION AS NEEDED FOR ANY OF THE ABOVE-STATED PURPOSES OR AS NECESSARY TO COMPLY WITH ZURICH'S LEGAL AND REGULATORY OBLIGATIONS, RESOLVE DISPUTES, AND ENFORCE ZURICH'S AGREEMENTS. YOU MAY REQUEST TO REVIEW THE PERSONAL INFORMATION ZURICH MAINTAINS ABOUT YOU AND MAKE CORRECTIONS BY WRITING TO: PRIVACY OFFICER, ZURICH INSURANCE COMPANY LTD (CANADIAN BRANCH), 100 KING STREET WEST, SUITE 5500, P.O. BOX 290, TORONTO, ON M5X 1C9 OR BY EMAILING PRIVACY.ZURICH.CANADA@ZURICH.COM.

YOU MAY REFUSE TO CONSENT OR WITHDRAW YOUR CONSENT TO THE COLLECTION, STORAGE, USE, DISCLOSURE OR PROCESSING OF YOUR PERSONAL INFORMATION; HOWEVER, YOUR REFUSAL TO PROVIDE CONSENT MAY PREVENT ZURICH FROM BEING ABLE TO INVESTIGATE, ADMINISTER, ADJUST AND SETTLE THE CLAIM.

PLEASE CONTACT THE ZURICH PRIVACY OFFICER IF YOU REQUIRE FURTHER INFORMATION REGARDING THE COLLECTION, USE, DISCLOSURE, PROCESSING AND STORAGE OF YOUR PERSONAL INFORMATION OR IF YOU HAVE ANY COMPLAINTS VIA EMAIL AT PRIVACY.ZURICH.CANADA@ZURICH.COM. YOU CAN ALSO REVIEW OUR PRIVACY POLICY AT HTTPS://WWW.ZURICHCANADA.COM/EN-CA/ABOUT-ZURICH/PRIVACY-STATEMENT.

FOR THE PURPOSES OF THE INSURANCE COMPANIES ACT (CANADA) THIS DOCUMENT WAS ISSUED IN THE COURSE OF THE ZURICH CANADA'S INSURANCE BUSINESS IN CANADA.

CERTIFICATION

THE STATEMENTS I PROVIDE IN COMPLETING THIS CLAIM FORM AND OTHERWISE IN RESPECT OF MY CLAIMS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. IN THE EVENT OF A FALSE OR MISLEADING STATEMENT IN THE MAKING OF THIS CLAIM, COVERAGE CAN BE CANCELLED, PAYMENT OF BENEFITS DENIED AND PAST CLAIMS PAYMENTS RECOVERED. I AGREE TO REFUND TO THE INSURER, THE AMOUNT OF ANY PAYMENTS MADE IN THE EVENT THAT SUCH AMOUNTS SHOULD NOT HAVE BEEN PAID IN RESPECT OF MY CLAIM.

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. THIS AUTHORIZATION SHALL BE CONSIDERED VALID FOR THE DURATION OF THE CLAIM, BUT NOT TO EXCEED ONE YEAR FROM DATE SIGNED.

I HEREBY CONSENT TO THE COLLECTION, USE AND DISCLOSURE BY THE INSURER, ITS AGENTS AND ADMINISTRATORS OF MY PERSONAL AND HEALTH INFORMATION SET OUT HEREIN, AND IN ALL DOCUMENTS, OR INFORMATION PROVIDED IN CONNECTION WITH MY CLAIM TO PROCESS, INVESTIGATE AND SETTLE MY CLAIM.

SIGNATURE: _____ DATE: _____