

Your travel insurance policy is underwritten by **The Manufacturers Life Insurance Company** ("Manulife"). Manulife has appointed Active Claims Management (2018) Inc., operating as Active Care Management ("ACM"), as the provider of all assistance and claims services under the policy.

IMPORTANT: The Authorization section must be completed in order to process your claim.

By signing this form you certify that the information provided in connection with this claim is complete, true and accurate.

SECTION A – CLAIMANT INFORMATION Please attach a list if there are more than two claimants.

Last Name	First Name	Date of Birth			
1		<input type="checkbox"/> Male <input type="checkbox"/> Female	MM	DD	YYYY
2		<input type="checkbox"/> Male <input type="checkbox"/> Female	MM	DD	YYYY
Address					
Email Address		Primary Phone Number	Secondary Phone Number		

SECTION B – CERTIFICATION AND AUTHORIZATION All adult claimants must sign below.

- This Authorization will permit Manulife and/or ACM to use the disclosed information for the purpose of determining my eligibility for coverage under my travel insurance policy and discuss any aspect of the adjudication of my claim with Manulife and its affiliates.
- I hereby authorize any doctor, hospital or facility providing medical or health-related services (any of which is a "Provider"), and any other insurer to release and exchange with Manulife and/or ACM or its representative, any information that is required to process this claim.
- I assign to Manulife 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 Manulife and/or ACM.
- A photocopy, facsimile, or electronic copy of this authorization shall be as valid as the original for the purpose of obtaining further information to process this claim

Attention to Travel Service Providers: I hereby authorize and direct that you release to Manulife or its representative any and all information you have regarding my travel or use of your travel services for the purpose of determining my eligibility for coverage under my travel insurance policy.

Notice: The provincial legislation in some provinces requires us to inform you that the time limit for taking legal action is set out in the Insurance Act or other legislation that applies to your claim.

I certify that the statements and particulars given herein together with those on any accompanying documents or telephone interviews relating to my claim are complete, true and correct to the best of my knowledge.

Manulife and ACM are committed to protecting the privacy, confidentiality and security of the personal information we collect, use and disclose. Your personal information will be used for the purpose of providing you with the requested insurance services. Your personal information may also be used to contact you about your customer experience and/or to participate in market research. For a copy of the privacy policies, please visit: www.manulife.ca and www.active-care.ca.

If a claimant is a minor, print full name of parent or legal guardian, or if a claimant is deceased, print full name of executor:

Signature of Claimant 1	MM	DD	YYYY
Signature of Claimant 2	MM	DD	YYYY

Assignment of Benefits Complete this section if you wish to direct the reimbursement to a designated person. If this section is left blank, any benefits payable under this claim will be assigned to each adult listed on the confirmation of insurance.

Payee	Phone
Payee Address	