



Group Medical Services

# Baggage Loss, Damage & Delay Claim Form

## Instructions

Please complete all sections and submit to: **Group Medical Services** 2055 Albert Street PO Box 1949, Regina, SK S4P 0E3

## A. Personal Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth DD / MM / YYYY

Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Tel ( \_\_\_\_\_ ) \_\_\_\_\_ Email \_\_\_\_\_ GSM Policy # \_\_\_\_\_

## B. Trip Information

Departure Date DD / MM / YYYY Return Date DD / MM / YYYY

Date of Loss or Damage DD / MM / YYYY Location of Loss or Damage \_\_\_\_\_

To whom was the Loss or Damage reported? *(If you have received a copy of the report, please include a copy to your claim)*

- Police       Hotel Management       Tour Guide       Airline       Other Transportation Authorities
- Other \_\_\_\_\_

How did the loss or damage occur?


## C. Other Insurance Coverage

**Please provide details** (attach additional information if necessary)

Do you have other insurance that may cover Loss or Damage to your Baggage?

Type of Plan \_\_\_\_\_ Policy/ID/Credit Card # \_\_\_\_\_

Name and Address of Bank/Credit Card or Insurance Company \_\_\_\_\_

Have you filed a claim?  Yes  No

## D. Declaration

1. If I recover any lost items or receive any amount as compensation in respect to any claim already paid by Group Medical Services, I will immediately mail full details to Group Medical Services.
2. I hereby state that the above information provided is true and correct to the best of my knowledge and believe that no material information has been withheld.

**Signature of Claimant** **X** \_\_\_\_\_ **Date** DD / MM / YYYY

**PLEASE COMPLETE SCHEDULE OF ITEMS ON REVERSE AND RETURN FORM TO GMS**

**Group Medical Services** 2055 Albert Street PO Box 1949, Regina, SK S4P 0E3 306.352.7638 or 1.800.667.3699  
Group Medical Services is the operating name for GMS Insurance Inc. in provinces outside of Saskatchewan.

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## E. Schedule of Items Lost or Damaged

Attach original receipt for each item and provide itemized receipts for replaced or repaired items.

Description of Items Claimed (state if item is a part of a set)	Original Date of Purchase	Original Price Paid	Replacement Cost	Estimated Repair Cost
	DD / MM / YYYY			
	DD / MM / YYYY			
	DD / MM / YYYY			
	DD / MM / YYYY			
	DD / MM / YYYY			
	DD / MM / YYYY			
	DD / MM / YYYY			
	DD / MM / YYYY			
	DD / MM / YYYY			
	DD / MM / YYYY			
	DD / MM / YYYY			
	DD / MM / YYYY			
	DD / MM / YYYY			

**Totals** \$ \_\_\_\_\_ \$ \_\_\_\_\_

**Payment** \$ \_\_\_\_\_