BAGGAGE LOSS, DAMAGE & DELAY
Claim Form

Please complete this form, sign, attach all documents and submit to Group Medical Services, 2055 Albert Street PO BOX 1949 Regina, SK S4P 0E3.

Be sure to include the following documents:

- ❑ Proof of travel dates
- ❑ Proof of claim with transportation carrier
- ❑ Proof of payment for all submitted expenses
- ❑ The police report *(if applicable)*

A. Personal Information

First Name	Last Name	Date of Birth *(DD/MM/YYYY)*	
Address	City/Town	Province	Postal Code
Phone ( )	Policy Number		
Email	☐ *Yes, I would like to receive emails about special offers, promotions and opportunities to provide feedback about GMS products and services.*		

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		

Who did you report the loss or damage to? *(If you received a copy of the report, please include a copy with your claim.)*

❑ Police ❑ Hotel Management ❑ Tour Guide ❑ Airline ❑ Other Transportation Authorities ☐ Other _____

How did the damage or loss happen?

C. Other Coverage Information *(please provide details and attach additional information if necessary)*

Do you have other insurance that may cover lost baggage or damage to your baggage? ❑ Yes ❑ No	Have you filed a claim? ❑ Yes ❑ No
Type of Plan	Policy Number/Credit Card Number
Name and Address of Bank/Credit Card or Insurance Company	

D. Lost or Damaged Items

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

Description of Item *(state if item is part of a set)*	Original Date of Purchase *(DD/MM/YYYY)*	Original Price Paid	Replacement Cost	Estimated Repair Cost
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
(To be completed by GMS Claims Department)		TOTALS	$	$
			PAYMENT	$

E. Declaration

I/We ("I") declare the statements made herein are true and complete. For the purposes of administering any Group Medical Services ("GMS") benefits, products or services (collectively "benefits") and/or determining eligibility for benefits, I authorize GMS to: (a) collect, store and use any personal information which I have provided to GMS or personal information obtained pursuant to clause (b); and/or (b) obtain personal information about me (or any other person listed herein) from, or disclose such personal information to any insurance company, or any other service provider or third party as may be reasonably required for the purposes described above. I warrant that neither I nor any person herein listed have any additional coverage through any insurer other than the information listed herein and hereby authorize GMS to coordinate any eligible expenses with any additional insurer listed herein. I understand that any misrepresentation, incorrect or concealed information or failure to fully complete all sections of this form may void my coverage. I declare that, if I am signing on behalf of any person(s), I have the authority to sign on behalf of such person(s) listed herein and confirm that each of the above declarations and authorizations are also provided on behalf of such person(s).

Signature of all Claimants 18 years of age and older	Date *(DD/MMYYYY)*
X	