AVIS BUDGET CAR RENTAL CANADA ULC

PERSONAL ACCIDENT CLAIM FORM

1 RENTERS REPORT

NAME OF RENTER: _____ DATE: _____

NAME OF CLAIMANT: _____

ADDRESS: _____ HOME PHONE: _____

_____ MOBILE PHONE: _____

CITY: _____ PROV: _____ POSTAL: _____ 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
  WORLD TRAVEL PROTECTION CANADA INC.
  SUITE 300, 901 KING STREET WEST
  TORONTO, ON
  M5V 3H5
  CANADA

FOR CLAIMS INQUIRIES, PLEASE CONTACT: 1-416-941-0448
OR 1-888-999-1971

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/POST MORTEM & TOXICOLOGY REPORT (IF APPLICABLE)
- ALL RELEVANT MEDICAL REPORTS TO SUPPORT CLAIM
- ATTACH A COPY OF YOUR RENTAL AGREEMENT

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.

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3 CLAIM DETAILS

WHERE ACCIDENT OCCURRED	DATE OF ACCIDENT (DD/MM/YYYY)
RENTAL DATE:	DATE REPORTED
RENTAL AGREEMENT NUMBER:	VEHICLE NUMBER
NAME OF RENTAL CAR COMPANY:	ADDRESS WHERE CAR RENTED (STREET, CITY, PROVICE, POSTAL CODE:
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

4 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:	

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

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? ☐ RIGHT ☐ LEFT	WAS EYE REMOVED? ☐ YES ☐ NO
WHICH EYE WAS INJURED? ☐ RIGHT ☐ LEFT	WAS EYE REMOVED? ☐ YES ☐ NO	
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 and Stamp 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 PLAN AND 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 CAUSE OF 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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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 STATEMENT

YOUR PERSONAL INFORMATION MAY BE PROCESSED AND STORED BY ZURICH INSURANCE COMPANY LTD (CANADIAN BRANCH) AND ITS AFFILIATES (COLLECTIVELY, "ZURICH") AND AUTHORIZED REPRESENTATIVES, BOTH IN DOMESTIC AND FOREIGN JURISDICTIONS OUTSIDE CANADA AND IS SUBJECT TO APPLICABLE LAWS. PLEASE CONTACT THE ZURICH PRIVACY OFFICER IF YOU REQUIRE FURTHER ADDITIONAL INFORMATION REGARDING THE COLLECTION, USE, DISCLOSURE, PROCESSING AND STORAGE OF YOUR PERSONAL INFORMATION VIA EMAIL AT PRIVACY.ZURICH.CANADA@ZURICH.COM OR YOU CAN REVIEW OUR PRIVACY STATEMENT AT HTTPS://WWW.ZURICHCANADA.COM/EN-CA/ABOUT-ZURICH/PRIVACY-STATEMENT.

YOU MAY REFUSE TO CONSENT TO THE COLLECTION, STORAGE, USE OR DISCLOSURE OF PERSONAL INFORMATION; HOWEVER, THE REFUSAL TO PROVIDE CONSENT MAY RESULT IN ZURICH BEING UNABLE TO OFFER AND ADMINISTER INSURANCE COVERAGE OR PREVENT ZURICH FROM BEING ABLE TO PAY CLAIM BENEFITS.

ZURICH IS COMMITTED TO PROTECTING THE PRIVACY AND CONFIDENTIALITY OF INFORMATION PROVIDED. YOUR FILE IS SECURED IN OUR OFFICES OR THOSE OF OUR ADMINISTRATOR OR AGENT. YOU MAY REQUEST TO REVIEW THE PERSONAL INFORMATION IT CONTAINS 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.

FOR THE PURPOSES OF THE INSURANCE COMPANIES ACT (CANADA) THIS DOCUMENT AS ISSUED IN THE COURSE OF THE ZURICH'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: _____