

**Canadian College Partnership Program (CCPP) – Phase II
TRAVEL INSURANCE FORM
FOR CANADIANS TRAVELLING OUTSIDE CANADA**

Please complete this form (a separate form for each person) for each person traveling on ACCC project business, and return it to ACCC Project Officer responsible for your project at Fax No. (613) 746-6721, **no later than two (2) weeks prior to departure date.** Once approved and processed by ACCC, confirmation and identification cards (as applicable) will be sent.

M/F	NAME OF TRAVELLER		PROVINCE OF RESIDENCE	DEPARTURE DATE	RETURN DATE	DESTINATION
	(SURNAME)	(GIVEN NAME)				
TO BE COMPLETED IF INSURANCE IS REQUESTED:	DATE OF BIRTH	EMERGENCY CONTACT PERSON (FAMILY, FRIEND, ETC.)			PHONE NUMBER:	

INSURANCE CONFIRMATION	REQUEST FOR INSURANCE
<p>This is to confirm that the health insurance coverage secured and provided by <u> (specify name of CCI) </u> for the traveller listed above, travelling on project-related business for ACCC Project Number meets the following minimum requirements and is in effect on the day of departure from Canada until and including the day of return:</p>	<p>We hereby confirm that we have verified the state of health of the traveller listed above and consider this person to be fit and able to travel.</p> <p>We hereby request the following insurance coverage and/or service:</p>
<p>(A) <input type="checkbox"/> Emergency Medical expense benefits (\$1,000,000 per person) <input type="checkbox"/> Accidental death and dismemberment coverage (2 members) (\$50,000 per person) We hereby decline insurance coverage with: <input type="checkbox"/> Student Guard</p>	<p>(B) We request health insurance coverage for the traveller listed above with: <input type="checkbox"/> Student Guard</p>
<p>(C) <input type="checkbox"/> Emergency medical services, sufficient to allow for evacuation and/or repatriation. We hereby decline enrolment in: <input type="checkbox"/> International SOS</p>	<p>(D) We request enrolment of the traveller listed above with: <input type="checkbox"/> International SOS</p>
	<p>Send invoice for this coverage to: Name: CCI:</p>
<p>Name and Signature of Authorized Signatory</p>	<p>Date (Year/Month/Date)</p>

NAME OF CCI	PROJECT NO.	PROJECT NAME	PROJECT COORDINATOR (CCI)
PROJECT OFFICER (ACCC)	CONTACT PERSON IN HOST COUNTRY		PHONE NUMBER
NAME OF PERSON SUBMITTING REQUEST/CONFIRMATION FORM		EMAIL:	PHONE NUMBER

Please complete the following questionnaire to enable us to gather data for CIDA Statistics:

A. Purpose of travel:

1. Coordination (7015) <input type="checkbox"/>	2. Technical Assistance (7215) <input type="checkbox"/>
3. Training Program (8115) <input type="checkbox"/>	4. Other (Please Specify) <input type="checkbox"/>

B. Specific Subject or Field of Specialisation: _____
(e.g. Veterinary Medicine, Fisheries Management, Electrical Eng.)

C. Nature of Assignment for CCI personnel: _____
(e.g. Manager, Evaluator, Advisor, Aid Administrator, Teacher, etc)

D. Approximate travel/training funds to be expended: _____
(Include airfare, accommodation, meals & incidentals)

E. Number of persons accompanying this Traveller: _____

F. Purpose of assignment: _____

FOR ACCC SECRETARIAT USE ONLY	
Request processed by: _____	Approved by (Project Officer): _____
Date confirmation sent to Project Coordinator: _____	By Fax <input type="checkbox"/> By E-mail <input type="checkbox"/>