can assistance

CLAIM FORM – TRAVEL INSURANCE

IMPORTANT NOTICE

A duly completed and signed claim form is necessary even if you haven't made any payments. Your public health insurance plan covers some of the fees for medical care received during your trip. CanAssistance reimburses these fees in full, but must submit them to your provincial health insurance plan.

In accordance to the terms of your contract, by signing the form you authorize CanAssistance to:

- Access your personal and medical information required to adjudicate your claim
- Pay eligible expenses to service providers directly

Failure to return the duly completed form entitles CanAssistance to ask you to refund the fees paid on your behalf.

Filing a claim

Complete the claim form(s) and sign where designated with an X.

- Each person who received healthcare services must complete a claim form.
- The form must be signed by the beneficiary (person who received healthcare services). If the claim involves a minor, the policyholder must sign the form.

Attach all the following documents:

- Original itemized bills for all healthcare services received, the diagnosis and treatment must appear clearly .
- Original prescription drug receipts showing the name of the drug, the dosage and the price.
- Proof of payment for all expenses claimed, such as a credit card statement or proof of a deposited cheque showing the currency in which the service was paid. In the absence of a bank or credit card statement, a receipt may be accepted.
- Proof of your departure and return dates, such as a plane ticket, a stamped copy of your passport, a bank or credit card statement showing purchases made in Canada just before your departure date and immediately after your return.
- Any other relevant document(s), such as medical reports, lab results, etc.

Make copies of all submitted documents for your files, as they will not be returned.

Send the completed forms and all other required documents by mail to:

Quebec :
CanAssistance
Travel Claims Department
1981, McGill College Avenue, Suite 400
Montreal, Quebec H3A 2W9

Ontario :
CanAssistance
Travel Claims Department
P.O. Box 4439, Station A
Toronto (Ontario) M5W 3Z4

Additional Information

Your claim will be reviewed as quickly as possible once we've received the required documents. The following situations may increase the time it takes us to process your claim:

- An incomplete claim form or missing document
- Delayed or missing detailed invoice
- Delayed or missing medical information

Eligible expenses are reimbursed in Canadian funds by cheque made out to the policyholder. If you're covered by more than one travel insurance policy, indicate this on your claim form. We will work with your other insurer to coordinate your benefits as needed.

If you receive a bill, please do not make any payments directly to the service provider unless we instruct you to do so. Simply send it to the address above.

Should you have any questions about your claim, please contact our customer service at 514 286-8336 or toll-free at 1 800 264-1852 Monday through Friday from 8:30 am to 5:00 pm or by email at claims@canassistance.com.

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CLAIM PROCESS

CANASSISTANCE - TRAVEL CLAIMS
DEPARTMENT P.O. BOX 4439, STATION A
TORONTO, ONTARIO M5W 3Z4

INSURER'S NAME	(Optional) GROUP NO.
CONTRACT NO.	(Optional) FILE NO.

MANDATE

1. I, the undersigned *(please print)*_____
Authorize CanAssistance inc. and its signing officers as my attorneys to receive in my name and endorse and negotiate on my behalf, cheques and other forms of payment from my provincial or territorial health insurance plan (OHIP) for the reimbursement of claims relating to hospital and medical services incurred during a trip outside my place of residence during my coverage period, including any authorized extension of such coverage, and in accordance with my travel insurance plan.

2. I irrevocably direct and authorize OHIP to make payment in respect of my claim for health services incurred during such trip to CanAssistance inc. directly and I hereby release OHIP, upon payment to CanAssistance inc. from any further claim or cause of action in connection therewith.

3. I hereby consent and authorize Canassistance Inc. and OHIP to directly or indirectly collect information contained in the claim and source documents pursuant to applicable provincial legislation.

4. I consent to the disclosure by OHIP to CanAssistance inc. of such personal information as may be necessarily required for the processing of my claim for such health services, including the details of any duplicate payment previously made directly to me.

5. I certify that the information contained herein is true and complete to the best of my knowledge and I hereby authorize any licensed physician, practitioner, hospital or medical institution, insurance company, OHIP, the Medical Information Bureau or any other agency, institution or person who has information or documents about me or a member of my family, or my state of health or that of a member of my family (including all previous medical reports) to convey that information or forward those documents to CanAssistance Inc.

X _____ _____

SIGNATURE OF THE BENEFICIARY **DATE**

If not the beneficiary, relationship (father, mother, etc.): _____

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A photocopy or a fax of this authorization shall be considered as valid as the original

BENEFICIARY

Provincial Health Insurance Card No.		LAST NAME (as appearing on health insurance card)	FIRST NAME (as appearing on health insurance card)		
NUMBERS	LETTERS (Version Code)	DATE OF BIRTH (Year / Month / Day)	GENDER ☐ M ☐ F	TELEPHONE - HOME	CELLPHONE

PLEASE COMPLETE AND SIGN THE BACK OF THIS FORM

CLAIM FORM – TRAVEL INSURANCE

FOR OFFICE USE

CONTRACT HOLDER (IF DIFFERENT FROM THE BENEFICIARY)

LAST NAME (as appearing on health insurance card)	FIRST NAME (as appearing on health insurance card)	DATE OF BIRTH (Year / Month / Day)	GENDER
			☐ M ☐ F

CONTRACT HOLDER DETAILS

NAME OF THE EMPLOYER

1	Home address in Ontario (No / STREET / Apt.)	POSTAL CODE	TELEPHONE
2	Address for correspondence or payment (if different) (No / STREET / Apt.)	POSTAL CODE	TELEPHONE
3	E-MAIL:		TELEPHONE - CELLPHONE

SEND **CHEQUE** TO: ☐ ADDRESS **1** ☐ ADDRESS **2** SEND **CORRESPONDENCE** TO: ☐ ADDRESS **1** ☐ ADDRESS **2**

STAY OUTSIDE ONTARIO

Trip during which you received healthcare services

Date of departure (Year / Month / Day)

Date of return in Ontario — Actual (Year / Month / Day) — Planned (if different) (Year / Month / Day)

Reason for trip (check one box only)

- ☐ Vacation or seasonal absence
- ☐ Work — Employer's name:
- ☐ Studies — Include a written certificate from the institution indicating the dates of the beginning and end of your courses
- ☐ Receive medical care — If you made a request of authorization to the OHIP, indicate the number
- ☐ Other — Specify:

REIMBURSEMENT

Amount claimed:

Currency:

- ☐ Canadian dollars
- ☐ Other currency (specify): _____

Were bills paid?

- ☐ No
- ☐ Yes

If yes, please specify:

- ☐ Totally
- ☐ Partially: _____ (Paid amount)

HEALTHCARE SERVICES OUTSIDE ONTARIO

Indicate why you received healthcare services:

In the case of an accident, specify the type of accident:

☐ Motor vehicle accident ☐ Work related ☐ Other (specify):

Date of the accident (Year / Month / Day)

Describe the services received (Ex.: tests, X-rays, surgery, etc.) If necessary, continue on a separate piece of paper

Where did you receive these services?

City

Canadian province or U.S. state

Country

If applicable, indicate the number of days you were hospitalized:

HEALTHCARE SERVICES IN ONTARIO

If you consulted a **doctor or a specialist** during the last 6 months prior to your trip, specify:

Name: _____

Address: _____

Nature of illness: _____

Date of last visit: (Year / Month / Day)

If you were **hospitalized** in Ontario during the last 6 months prior to your trip, specify:

Nature of illness: _____

Name and address of hospital : _____

File Number : _____

List all **medication(s)** taken in the 6 months prior to your trip.:

OTHER INSURANCE

Complete the section below if you have other travel insurance coverage

Other travel insurance or Group Insurance: _____ (Name of the insurance company) Policy No: _____ Certificate No: _____

Bank credit card: _____ (Name of the financial institution) Card No _____ Expiry date

PLEASE COMPLETE AND SIGN THE FRONT OF THIS FORM