CanAssistance

CLAIM FORM – TRAVEL INSURANCE

CLAIM PROCESS

A. Fill out the insurer's name, the group number, the contract number and the file number
B. Complete both sides and SIGN THE CLAIM FORM
C. Original copy of the documents is required in all cases. Keep a copy for your records and send in the originals to the following address :
D. Failure to indicate your Ontario health insurance number with the version code (one or two letters on your health card) shall result in the compensation being refused

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

INSURER'S NAME	GROUP NO.
CONTRACT NO.	**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.): _____

01QRV0013B-A (15-08)

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.:

COORDINATION OF BENEFITS

To proceed with the coordination of benefits, please specify:

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