BLUE CROSS®
TRAVEL INSURANCE

CLAIM FORM – VISITORS TO CANADA

CLAIMS PROCESS

A. Complete both pages of the « Claim Form – Visitors to Canada ».
B. Sign the « Assignment of Benefits » section if applicable.
C. Sign the « Agreement and Authorization » section. If patient is a minor, a parent or legal guardian must sign the form.
D. Send all duly completed forms as well as any other required documents to CanAssistance.

By email:	By regular mail:
info@qc.bluecross.ca Send all scanned documents and keep originals	Blue Cross, Travel Claims Department P.O. Box 910, Station B, Montreal, Quebec, H3B 3K8

INSURANCE COMPANY	GROUP NUMBER (Optional)
CONTRACT NUMBER	**FILE NUMBER (Optional)**

Policyholder

Last name	First name	Date of birth (Year / Month / Day)	Gender ☐ M ☐ F
Email		Telephone 1	Telephone 2
Country of origin		Relationship to patient (if different from policyholder)	

Address in Canada

no	Street	Apt.	City	Province	Postal Code

Assignment of benefits

Are eligible benefits payable to a person other than the policyholder? ☐ Yes ☐ No If yes, please specify who the cheque should be issued to.

Name and address of the person: ______________________________

______________________________ ______________________________

Signature of policyholder

Patient (if different from policyholder)

Last name	First name	Date of birth (Year / Month / Day)	Gender ☐ M ☐ F

Information about your trip

Stay in Canada

Arrival date in Canada (Year / Month / Day)	Departure date from Canada (Year / Month / Day)

Stay in the U.S.

Departure date from Canada (Year / Month / Day)	Return date to Canada (Year / Month / Day)

Reason for trip

- ☐ Vacation
- ☐ Immigration
- ☐ Studies, name of institution: ______________________________
- ☐ Work, name of employer: ______________________________
- ☐ Other, specify: ______________________________

Agreement and Authorization

1. I hereby agree to assign to Canassurance Hospital Service Association and CanAssistance Inc. (hereinafter called the Insurer) all benefits payable by third parties for losses covered under the policy. Furthermore, following the application for reimbursement from CanAssistance Inc., I authorize third parties to pay CanAssistance Inc., the benefits payable regarding these losses.
2. I authorize the Insurer to provide the information contained in my claim file to third parties, for their use, within the context of this claim, to determine the benefits payable, if the case arises.
3. I authorize the Insurer to make payments pertaining to the expenses claimed, directly, when required, to any institution and/or any other provider of services.
4. To assess my application for benefits, I authorize any licensed physician, practitioner, hospital or medical institution, insurance company, or any other agency, institution or person, who have information necessary to analyze my application, to convey that information to the Insurer. I understand that said information may be disclosed when required to its reinsurers, to internal and external auditors and to any professional or organization mandated by the Insurer within the context of processing my application for benefits. This authorization is valid until the final settlement of my claim.
5. I declare that the information and details given on this form and the information provided in the attached documents are complete and true, and I am aware that any false declaration shall nullify the insurance certificate or insurance policy and shall result in the denial of my application for benefits.

Signature of Policyholder or legal heir: ______________________________ Date : ____________

Signature of Patient (if different from policyholder): ______________________________ Date : ____________

01CAN0016A (11-19)

CLAIM FORM – VISITORS TO CANADA

FOR OFFICE USE

Services and care received

Date when first symptoms appeared or accident occured
Year | Month | Day

City and country where services were received

Indicate the reason why you received medical and/or hospital care

____

____

Describe services received (e.g.: examination, x-ray, surgery, etc.). Please use a separate sheet if needed.

____

____

____

If claiming due to an accident, please specify:

Date of accident
Year | Month | Day

Type of accident

☐ Motor vehicle ☐ Work ☐ Other, specify: ____________

Amount Claimed

Amount claimed: ____________

Currency:

☐ Canadian Dollars

☐ Other, specify: ____________

Were bills paid?

☐ Yes

☐ No

If yes, please specify:

☐ Totally

☐ Partially ____________
Paid amount

Other Insurance

Do you, your spouse or child have another travel insurance? ☐ Yes ☐ No If yes, please provide the following information:

Policyholder ____________ Insurance Company ____________

Policy number ____________ Company phone number ____________

Identification number ____________

Have you already initiated a claim? ☐ Yes ☐ No If yes, please indicate the file number: ____________

Medical Information

If the patient consulted a doctor or specialist in the 6 months preceeding the effective date of the policy, please provide:

Physician name / Medical Facility	Telephone / Email	Nature of the illness or accident	Date of service		

If the patient was hospitalized in the 12 months preceeding the effective date of the policy, please provide:

Hospital name	Telephone / Email	Nature of the illness or accident	Admission date Year / Month / Day
Address (city and country)			Discharge date Year / Month / Day

Please provide the names of all the medicines the patient was taking in the 6 months preceeding the effective date of the policy:

____

____

Essential Documents to Submit

- The « Claim Form – Visitors to Canada » duly completed and signed.
  - If more than one person received care, you will need to complete a claim form for each person.
  - If the claim involves a person who is a minor, the policyholder or legal heir must sign the form.
- The detailed invoices and proof of payment.
  - Invoices for medical care must show the diagnosis and treatment.
  - Invoices related to the purchase of prescription medication must show the name of the drug, the dosage and the price.
  - Valid proof of payment may include a credit card statement or proof of a deposited cheque, and the currency in which the service was paid must appear. In the absence of a bank or credit card statement, a receipt may be accepted.
- Any other relevant document(s), such as medical reports, lab results, etc.

An incomplete claim may cause additional delays in processing your file. If you can't submit all requested documents, please provide us with an explanation in a letter attached to your claim. We reserve the right to request the original documents or additional information if needed. Please keep a copy of your supporting documents for your records.

Should you have any questions about your coverage or the claims process, please contact our customer service at 514-286-6690 or toll-free at 1 800 387-2538 Monday through Friday, from 8:30 am to 5:00 pm (Eastern Time).