CANADIAN EXPATRIATES EMERGENCY MEDICAL EXPENSE CLAIM FORM

Global Assistance

Please complete, sign and return promptly to Allianz Global Assistance.
Without this information, we are unable to proceed with your claim.

P.O. Box 277
Waterloo, ON Canada
N2J 4A4

PATIENT INFORMATION

Patient Name (First, Last): ______________________ Case: ______-______

Address Abroad: ______________________

City: __________ State/ Province: __________ Country: __________ Postal Code: __________

E-mail: ______________________ Can we contact you via Phone / E-mail? (circle preference)

Patient's Date of Birth: __________ (MM/DD/YYYY) Gender: ☐ M ☐ F ☐ X Patient's Relationship to Policyholder: __________

Policyholder Name: ______________________

Policy No.: __________ Policyholder's Date of Birth: __________ (MM/DD/YYYY)

Have you paid for treatment? ☐No ☐ Yes: Total amount being claimed: $__________

If "Yes", please specify service provider name, amount paid and currency of payment. If you have additional expenses please attach an additional page.

☐Partial or ☐Paid in Full (submit proof of payment) Service provider name: __________ Amount Pd: __________

☐Partial or ☐Paid in Full (submit proof of payment) Service provider name: __________ Amount Pd: __________

☐Partial or ☐Paid in Full (submit proof of payment) Service provider name: __________ Amount Pd: __________

Please indicate which address you wish payment to be made to: ☐ Address Abroad or ☐ Address in Canda (listed in the Authorization section below) if trip has ended at time of claim

*** **Please note:** All claim payments will be in Canadian Dollars. Claim payments that would violate any applicable national economic or trade sanctions law or regulations are prohibited.

DIRECTION AND AUTHORIZATION TO PHYSICIANS, HOSPITALS AND OTHER MEDICAL PROVIDERS

By signing this form, I hereby authorize and direct any physician, health care facility, treatment provider, plan administrator, any insurance company, reinsurer, provincial health insurance plan, government department (collectively, "Third Party") having medical or other relevant personal information[1] regarding me, my spouse and/or dependent to disclose, release, share and exchange information with Allianz Global Assistance, its underwriter, plan administrator, agent or representative any and all such information necessary for the purposes of determining my eligibility, assessing my application, investigating and confirming the accuracy and validity of my claim, and administering or processing my claim. I am authorized to act on behalf of my dependants for these purposes. The authorization and direction I provided herein shall be good and sufficient authority, and any copy of this completed form is as valid as the original. My consent and authorization shall remain valid for the duration of my claim unless I revoke these in writing.

Full Name of Patient/Insured (Please print): ______________________ Date: __________ (MM/DD/YYYY)

I authorize payment of this claim to (print name): ______________________

Signature of Insured (if minor, signature of parent or legal guardian): ______________________

Signature of policyholder of other insurance in Section 2 (if applicable): ______________________

[1] IMPORTANT: Personal information excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

TRAVEL DETAILS

Date of Departure from Canada : ____________________ (MM/DD/YYYY) Date of Return: ___________________ (MM/DD/YYYY) Destination: ______________________________

Nature of Travel: ☐Business ☐Vacation ☐Study ☐Medical Care ☐Other: ____

Mode of Travel: ☐Car ☐Airplane ☐Other: ____

If applicable, was Extension of Coverage purchased? ☐No ☐Yes (specify)

____

OTHER INSURANCE INFORMATION FOR COORDINATION OF BENEFITS

Please indicate all other insurance coverage you have through any other insurer which covers you while abroad: (i.e. credit cards with insurance benefits, or any other purchased travel plan). Attach an additional page if required.

Name of Insurer: ____ Phone: _________________________

Address: ____

Lifetime payable limit on policy? ☐No ☐Yes (specify) $__________________________

Policy No: __________________ Certificate No: _______________________ Signature of Policyholder: _____________________________________

Credit Card Insurance coverage: Include card type and bank: ____

Number:____

Have you submitted these bills to any of the above listed insurance company? ☐No ☐Yes

If yes, which company?____

MEDICAL INFORMATION

Please describe briefly, the situation leading you to seek medical attention, including the diagnosis.

____

____

Were medical services required as result of an accident? ☐Yes ☐No If "Yes", please provide details and include an accident report with this form.

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____

Name of Hospital: ____ Date of Occurrence: _________________________ (MM/DD/YYYY)

Have you had any of these symptoms/conditions before? ☐Yes ☐No If "Yes", indicate the date you were **last** treated: ________________________ (MM/DD/YYYY)
(including medications)

Please list all medications prescribed and taken **before** your departure from Canada:

____

____

____

When were your medications **last** changed **before** your departure (includes type and dosage): __________________________ (MM/DD/YYYY)

Name, Address and Phone No. of your Family Physician: ____

____

Name, Address and Phone No. of any Medical Specialist:____

____

Date of your **last** medical visit before your trip? _______________________ (MM/DD/YYYY)

AUTHORIZATION

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that I have completed this claim form and that the answers given on Page 1 and Page 2 are complete, current and accurate to the best of my knowledge and belief.

I acknowledge that the submission of a false, incomplete or misleading information in the making of this claim, coverage can be void, payment of this claim denied and any claim payments made in error shall be recovered.

I authorize any physician, hospital or other medical provider who has attended or examined me to release to and exchange with Allianz Global Assistance or its representatives any and all information[1] regarding my medical history, symptoms, treatment, examination or diagnoses for the purpose of adjudicating my claim.

I authorize any other insurance carrier to release and exchange with Allianz Global Assistance or its representatives any medical or benefits payment information[1] relating to this claim.

I understand that if I am a dependant under this insurance coverage, the named insured will have access to information related to this claim in connection with the administration of this plan.

I agree that a photocopy or facsimile of this authorization shall be valid as the original and that this authorization shall be considered valid for the duration of this claim, but not to exceed two years from the date it is signed. I understand information about me may be reviewed in the event that this plan is audited.

Name of Patient (Please print): ______________________________ Date: ______________________
(MM/DD/YYYY)

Address in Canada: ____

Signature of **Patient / Designated Legal Proxy** *: ______________________________ Phone No: ______________

Signature of **Policy Holder**: ______________________________ Date: ______________________
(MM/DD/YYYY)

* If the patient is a minor, his/her legal guardian must sign on his/her behalf. If a legal representative other than the patient's legal guardian signs this form, (power of attorney, executor/executrix etc.) we require proof of "Legal Representative" status.

[1] IMPORTANT: All information excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

If sending original documents, be sure to keep a copy for your records.
If you have questions, please call us at 1-800-363-1835 (within North America), 011-1-519-742-2800 (from outside North America) or e-mail us at caclaimsInquiry@allianz-assistance.ca.