Medical claim checklist
for non-Canadians

Allianz
Global Assistance

To start your claim, follow the steps outlined in the checklist below.

- ☐ To complete this form electronically, save and name it using your case number, if you have it, and full name. (e.g. 1234567-First Name, Last Name.pdf).
- ☐ Complete this claims package in full – we want to confirm we have all the right information for you.
- ☐ Gather and scan:
  1. Doctor's records, documents and invoices from the medical facility.
  2. Receipts for out-of-pocket expenses, including proof of payment (i.e. credit card statement showing only last 4 digits and/or receipts matching your bills and expenses).
  3. Prescriptions (official receipts including medication name, dosage and cost – not the store purchase receipt).
  4. Proof of departure from your home country or arrival date in Canada.
- ☐ If you have already started your claim by contacting us, add your case number to this form and all of your documents, receipts, invoices, etc.
- ☐ If you need more space, use the additional information section at the bottom of this form.
- ☐ Send this claim form and supporting documentation to us at submit@allianz-assistance.ca. Be sure to include your case number, if you have it, in the subject line.
- ☐ Keep everything! This includes all original receipts, records, invoices, itineraries, supporting documentation and your claim form for a period of 1 year from the date of this submission. We might need you to mail them to us for verification.
- ☐ If you prefer, you can send your documents by mail:

  Allianz Global Assistance
  P.O. Box 277
  Waterloo, Ontario, Canada N2J 4A4

Here's what you can expect

- If we are missing information, we will contact you.
- Each claim is unique, and some may require records from the medical facilities where you were treated along with clinical notes from your family doctor and/or specialist at home. Obtaining these records may take time.
- Once we review your claim, you will receive your Explanation of Benefits in the mail.

Thank you and take care,
The Claims Team, Allianz Global Assistance

Medical claim form
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Global Assistance

Case/Claim number

Certificate/Policy number

Policyholder

First name _____ Last name _____

Date of birth (MM/DD/YY) _____

Tell us about yourself (all questions on this form relate to the patient, unless otherwise specified)

First name _____ Last name _____

Relationship to Policyholder _____ Date of birth (MM/DD/YY) _____

Email _____

Phone number _____ Alternate phone number _____

Your home country _____

Date you arrived in Canada (MM/DD/YY) _____ Date you left your home country (MM/DD/YY) _____

Home address in country of origin

_____

_____

Mailing address in Canada

Street _____

City _____ Province _____ Postal code _____

Tell us about your medical history **BEFORE** you arrived in Canada

*We need to ask you a few medical questions to collect the information we need to review your claim. For additional doctors / specialists, use the **Additional Information** section at the end of this form.*

Who are your doctors / specialists in your home country?

First name _____ Last name _____

First and last name _____

Area of specialty _____

Address _____

Phone _____ Fax _____ Email _____

Date of last visit (MM/DD/YY) _____ Reason for visit _____

Medical condition	Medications	Pending medical tests, procedures or follow-ups and their dates

Case/Claim number

Certificate/Policy number

Tell us about your medical claim

Name of treating medical facility or physician _____

Phone _____ Email _____

Address _____

Number of visits _____ Date of last visit (MM/DD/YY) _____ Reason for visit _____

If you got sick, tell us what happened

When did you first notice symptoms? (MM/DD/YY) _____

When did you first seek treatment? (MM/DD/YY) _____

Have you experienced this sickness or a similar problem before? ☐ Yes ☐ No **If 'Yes'**, when? (MM/DD/YY) _____

How were you feeling, what were your symptoms, and what was the diagnosis?

Was your condition due to pregnancy? ☐ Yes ☐ No

If 'Yes', when did you find out you were pregnant? (MM/DD/YY) _____ Expected date of delivery (MM/DD/YY) _____

If you were injured (i.e. slip and fall, car accident), tell us what happened

When? (MM/DD/YY) _____ Where? _____

How?

If your injury (i.e. slip and fall) occurred on private property (i.e. homeowner, hotel, etc.):

Property owner or location of incident _____ Phone number of property owner _____

Email of property owner _____

Did you file a report with the property owner (homeowner, hotel, etc.) or city responsible? ☐ Yes ☐ No **If 'Yes'**, when? (MM/DD/YY) _____

Please provide a copy of the report with this form. If no copy of the report is available, what is the report number? _____

If your claim relates to a motor vehicle accident, please provide the following information:

Did you file a report? ☐ Yes ☐ No **If 'Yes'**, where? ☐ Police ☐ Rental agency ☐ Collision reporting centre

Vehicle I was in:

Make/model	Name of auto insurance company	Phone number of auto insurance company	Vehicle owner	Policy number	Claim number (if applicable)

☐ I was driving ☐ I was a passenger ☐ I was a pedestrian

Case/Claim number

Certificate/Policy number

Other vehicles involved:

Please complete this section if you **DO NOT** *have a police report or a collision center self-report to produce with this claim form.*

Make/model	Name of auto insurance company	Phone number of auto insurance company	Vehicle owner	Policy number	Claim number (if applicable)

Did you seek legal counsel for either your injury or motor vehicle accident? ☐ Yes ☐ No

If 'Yes', provide**:**

Name of legal counsel _____ Law firm _____

Email _____ Telephone number _____

Tell us what you're claiming for

If you have additional expenses, please use the extra page at the end of this form.

Expense type (for example: physician services, medications, meals, accommodation)	Date of service (MM/DD/YY)	Amount billed	Amount you paid	Currency

Tell us about any other insurance you may have

Do you have additional coverage with another insurer? ☐ Yes ☐ No **If 'Yes'**, we will contact them and co-ordinate insurance benefits on your behalf.
If you have any other insurance policies, please check below and fill in the supporting information:

☐ Group benefits: Name of company _____ Policy/certificate number _____

Policy holder name _____ Date of birth (MM/DD/YY) _____

☐ Credit card: Name of card _____

Primary card holder _____ First 6 digits _____ Last 4 digits _____

Card holder date of birth (MM/DD/YY) _____

☐ Other travel insurance policies:

Name of company _____ Policy number _____

Policy holder name _____ Date of birth (MM/DD/YY) _____

Have you already contacted your other insurance about this claim? ☐ Yes ☐ No

If 'Yes', name of insurance company _____ When? (MM/DD/YY) _____

Have you applied for provincial health insurance in Canada? ☐ Yes ☐ No

If 'Yes', provide number: _____

Case/Claim number

Certificate/Policy number

Give permission to Allianz to discuss your claim with someone other than you

I authorize Allianz to discuss the details of my claim with (First and Last name) _____.

Relationship to me _____ Phone _____

Email _____

My Consent and Authorization

Check off each section to confirm you agree, and type your name into the patient signature field below.

☐ By signing below, I am certifying that the information provided in connection with this claim is complete, true and accurate. I understand that any incomplete, misleading or false information may lead to: (1) my coverage being voided, (2) my claimed expenses being denied, (3) claim payments that were made in error being recovered from me or (4) any combination of (1)-(3) being taken by AZGA.

☐ Personal Information Authorization

I understand that the personal information provided with respect to this claim is required by the insurer, administrator, and agents ("we") for the purpose of assessing entitlements to benefits and administering this claim. We may disclose the information collected to third parties within and outside of Canada for the purpose of providing assistance with administering your claim. Transfer of information is in accordance with the Allianz Binding Corporate Rules, which guarantee secure protection of personal data and are legally binding on all Allianz Group companies. All active personal information will be retained and stored within Canada for a period of seven (7) years.

I authorize and consent to the release, exchange, or disclosure of my personal or medical information[1] with any medical provider, healthcare facility, insurance company, reinsurer, government department and/or legal representative with Allianz Global Assistance, its underwriter, plan administrator, agent or representative for the purpose of assessing, investigating, administering, processing and/or subrogating this claim.

I understand I have the right to access, amend, delete and obtain a copy of personal information held by Allianz Global Assistance on my behalf. I further acknowledge I have the right to withdraw consent to the processing of my personal information as described within this authorization; however, any withdrawal of consent may prevent Allianz Global Assistance from being able to process my claim.

All individuals are entitled to contact the Allianz Global Assistance Privacy Officer for more information about our Privacy Policy or the processing of their personal information at: **Data Privacy Officer,** 4273 King Street East, Kitchener, Ontario N2P 2E9, privacy@allianz-assistance.ca.

☐ Payment Authorization

For payments made on my behalf, I authorize any benefits paid or payable by any other insurance carrier in respect to this claim, to be assigned in whole or in part to Allianz Global Assistance, or if directed by Allianz Global Assistance, to the insurance company issuing the policy for payment being made.

If you wish to have benefits payable to you by Allianz Global Assistance made out to someone other than yourself, please complete the following authorization:

I authorize payment of this claim to be made out to (please print):

First name _____ Last name _____

☐ I acknowledge and agree that entering my name in the signature line below constitutes my signature, acceptance, and agreement to all of the terms and conditions provided herein with the same binding effects whether signed manually or electronically. Delivery of this claim form bearing an electronic signature to Allianz Global Assistance by way of email in portable document format (PDF) shall have the same effect as if it were physically delivered.

Patient signature _____ Date (MM/DD/YY) _____

Print name _____

Signature of designated legal proxy * _____

Print name of designated legal proxy * _____

* ***For minors:*** *If the patient is a minor, their legal guardian must sign on their behalf.*

* ***For legal representatives:*** *If a legal representative signs this form (power of attorney, executor/executrix, etc.), the provincial health plan requires proof of "Legal Representative" status.*

[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.

A photocopy of this authorization shall be considered as effective and valid as the original for the duration of this claim, not to exceed two (2) years from the date signed.

Case/Claim number

Certificate/Policy number

Tell us what you're claiming for

Expense type (for example: physician services, medications, meals, accommodation)	Date of service (MM/DD/YY)	Amount billed	Amount you paid	Currency

Additional information