

EMERGENCY HOSPITAL & MEDICAL INSURANCE FOR CANADIANS CLAIM FORM

TIC Claims Department
1200 – 438 University Avenue
Toronto, Ontario, Canada M5G 2K8
Collect worldwide: 416-340-8809
Toll free Canada/U.S.A.: 1-800-869-6747

INSTRUCTIONS

IMPORTANT

- In the event of hospitalization, TIC Travel Insurance Coordinators Ltd. (TIC) must be notified prior to, or within 24 hours of admission to hospital, and prior to any surgery or invasive investigations being performed.
- All claims must be reported within 30 days of occurrence.
- Written proof of claim must be submitted within 60 days of occurrence.
- You are responsible for any fees charged for completing this form or issuing supporting documentation.
- This form must be completed by the insured, or if a minor, by the legal guardian or parent.

REQUIREMENTS

- Completed and signed claim form and **Emergency Hospital & Medical Insurance for Canadians Medical Certificate**.
- Claim form must be completed by a parent or legal guardian if the insured is a minor.
- All original bills and/or receipts. Photocopies will not be accepted.
- All bills must be itemized and show dates and costs of all treatment received.
- For Multi-trip Plans, include proof of original departure from and return to your province or territory of residence, such as airline tickets, customs stamp, or other evidence acceptable to TIC.
- Please refer to the claims procedures in the policy booklet or your agent for details on what is required to substantiate your claim.

SECTION A: CLAIMANT INFORMATION

Insured's First Name: _____ Last Name: _____
 Male Female Date of Birth: **MM/DD/YYYY** Policy #: _____
Telephone: () _____ Fax: () _____ Email: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Destination: _____ Departure Date: **MM/DD/YYYY** Return Date: **MM/DD/YYYY**

SECTION B: MEDICAL INFORMATION

In the case of an injury, how, when and where did it happen?

Please provide the following information if your claim relates to a motor vehicle accident

Name and Address of Auto Insurance Company Name: _____
Street Address: _____
City: _____ Province: _____ Postal Code: _____
Telephone: () _____ Policy number with auto insurance company: _____

If your claim is due to sickness, when did symptoms first appear? **MM/DD/YYYY**

Date of first treatment: **MM/DD/YYYY** What is the diagnosis? _____

Have you experienced this sickness or a similar problem before? Yes No If 'Yes', when? **MM/DD/YYYY**

Treating Doctor's Name: _____ Telephone: () _____

Please provide the names of any medications you were taking prior to visiting the doctor:

Do you have any chronic sickness or disease? Yes No If 'Yes', please provide date diagnosed and describe condition/diagnosis: _____

Date: **MM/DD/YYYY** Diagnosis: _____

Name and Address of usual Family Physician Name: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: () _____ Fax: () _____

Was the condition related to pregnancy? Yes No

If 'Yes', date of last menstrual period: **MM/DD/YYYY** Expected delivery date: **MM/DD/YYYY**

Was the condition related to the use of alcohol, misuse of drugs, or self-inflicted injury? Yes No

If 'Yes', please provide details:

SECTION C: EXPENSES CLAIMED

Amounts paid by you will be reimbursed to you if claim is eligible. Otherwise amounts will be paid directly to the provider of service. You are financially responsible for the expenses not covered by your insurance.

Name of Service Provider (for example: doctors, hospital, clinic)	Date of Service	Amount Billed	Amount You Paid
1.	MM/DD/YYYY		
2.	MM/DD/YYYY		

SECTION D: PROVINCIAL GOVERNMENT HEALTH INSURANCE (GHIP) AUTHORIZATION AND ASSIGNMENT

Residents of Alberta, Saskatchewan, Ontario, Nova Scotia, PEI, and all territories must complete this form in full. Residents of BC, Quebec, and Newfoundland must complete additional forms.

I agree that, according to the terms of this policy and in respect of my applicable provincial government health insurance (GHIP) legislation pertaining to freedom of information and protection of privacy; and in consideration of any monies TIC may advance to me as a result of the issuance of this policy, I hereby irrevocably:

- 1) Direct and authorize GHIP to make payment in respect to my claim for out-of-country health services to TIC directly and I hereby release GHIP, upon payment to TIC, from any further claim or cause of action in connection herewith; and
- 2) Consent and authorize GHIP to directly or indirectly collect information contained in the claim and source document pursuant to Section 39(1) of the Freedom of Information and Protection of Privacy Act, and Section 4(2)(f) of the Health Insurance Act in Ontario only, and
- 3) Consent and authorize GHIP to furnish to any representative of TIC such records and information as may be required for the processing of my claim for out-of-country health services, including the details of any duplicate payment previously made directly to me.

Insured's Signature: _____ Date: **MM/DD/YYYY** GHIP #: _____

Witness Signature: _____ Date: **MM/DD/YYYY** Version Code: _____
(Ontario Residents only)

SECTION E: OTHER INSURANCE COVERAGE (If the insured is a minor, this section is applicable to a parent or legal guardian)

Do you have any other travel or out-of-country medical insurance coverage through your employer, your spouse's employer or a retiree plan?

Yes No If 'Yes', provide details below.

Plan	Name of Insurance Company	Group Policy #	Member ID#	Telephone
Your Employer				()
Your Spouse's Employer				()
Retiree Plan				()

Name of Spouse: _____ Spouse's Date of Birth: **MM/DD/YYYY**

Do you have insurance benefits available through homeowner's insurance, automobile insurance or any other source?

Yes No If 'Yes', provide details below.

Plan	Name of Insurance Company	Policy #	Telephone
Homeowners Insurance			()
Automobile Insurance			()
Other			()

Do you have credit card insurance coverage for travel outside your province? Yes No

Name and address of issuing bank for credit card Name: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

First 6 digits of credit card #: _____ Expiry Date: **MM/YY**

Name of Cardholder (please print): _____ Cardholder Signature: _____
(if different from insured)

Insured's Signature: _____ Date: **MM/DD/YYYY**

SECTION F: AUTHORIZATION AND CERTIFICATION

TIC is committed to protecting the privacy, confidentiality and security of the personal information we collect, use and disclose. Your personal information will be used only for the purpose of providing you with the requested insurance services. For a copy of TIC's privacy policy, please contact us.

I authorize any doctor, hospital or facility providing medical or health-related services, and any other insurer to release and exchange with TIC or its representatives, any information that is required to process this claim. I assign to TIC any benefits payable from any other sources for losses covered under this policy, and I authorize and direct such payors to forward payment directly to TIC. I also authorize any third party providing me with assistance in this claims process, to have access to any and all relevant claims information related to the adjudication of my claim with TIC. I confirm I am authorized to act on behalf of my dependants for these purposes. A photocopy of this authorization shall be as valid as the original. I certify that the information provided in connection with this claim is complete, true and accurate.

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 E (if applicable): _____