

Schedule A

ASSIGNMENT OF PAYMENT DUE TO INSURED PERSON OR BENEFICIARY
UNDER THE SASKATCHEWAN MEDICAL CARE INSURANCE ACT
OR THE SASKATCHEWAN HOSPITALIZATION ACT

BETWEEN: _____ of the first part,
(claimant's name) _____ hereinafter referred
_____ to as the Assignor

AND: O/A TIC Travel Insurance Coordinators Ltd. of the second part,
hereinafter referred
to as the Assignee

AND: HER MAJESTY THE QUEEN IN THE RIGHT hereinafter referred
OF THE PROVINCE OF SASKATCHEWAN AS to as the Minister
REPRESENTED BY THE MINISTER OF HEALTH

WHEREAS the Assignor is a person eligible for medical services under The Saskatchewan Medical Care Insurance Act or The Saskatchewan Hospitalization Act or both, and as such may receive payment for the above services from the Minister.

AND WHEREAS the Assignor is under a covenant or obligation under a contract with the Assignee to remit to the Assignee all such payments received for medical services from the Minister.

NOW WITNESSETH THAT in consideration of the said obligation to the Assignee the Assignor hereby assigns unto the Assignee all sums of money that shall be owing to the Assignor by the Minister for the above noted contract. The Minister is hereby authorized to pay all such sums directly to the Assignee at the aforesaid, or at any address the Assignee may from time to time designate, with payment of any such sum to be sufficient discharge to the Minister of and from any indebtedness in that amount to the Assignor, his heirs, executors, or administrators.

DATED this _____ day of _____, 20 _____

Signature of Assignor

WITNESS:

_____ Signature

_____ Occupation

ASSIGNMENT:

Effective from / /
DD MM YY

To / /
DD MM YY

Schedule B

AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

I, _____ (or I, _____ parent/guardian of _____, a minor) hereby consent to and authorize the Department of Health to furnish to any representative of TIC Travel Insurance Coordinators Ltd. claim and payment information in the Department of Health's possession in respect of claims for Medical Services incurred while I had insurance coverage from _____ to _____ and may include payment and claim information for the period within 6 months prior to the date of service of the aforementioned Medical Services including physician/hospital name, date of service, and service provided (in-patient, out-patient, physiotherapy, visit, procedure, x-ray or laboratory service).

DATED this _____ day of _____, 20 _____

Health Services Number

Signature

Address

Telephone