

EMERGENCY MEDICAL EXPENSE CLAIM FORM

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

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

**or P.O. Box 71987
Richmond, VA USA
23255-1987**

PATIENT INFORMATION

Patient Name: _____ Case # _____
 Address: _____ City: _____ Province: _____ Postal Code: _____
 Patient's Date of Birth: _____ Male Female Patient's Relationship to Policyholder: _____
MM/DD/YEAR
 Patient's Provincial Health Card Number (including version code for residents of Ontario): _____

INSURER'S INFORMATION

Policyholder Name: _____
 Policyholder's Date of Birth: _____ Mondial Assistance Group #: _____ Green Shield I.D. #: _____
MM/DD/YEAR

TRAVEL DETAILS

Was this your 1st trip outside your home province this year? Yes No, this was my _____ stay outside my home province this year.
 Departure Date: _____ Anticipated/Scheduled Date of Return: _____ Actual Return Date: _____
MM/DD/YEAR MM/DD/YEAR MM/DD/YEAR
 Nature of Travel: Business Vacation Study Medical Care Other: _____

OTHER INSURANCE INFORMATION (if applicable, include spousal information for co-ordination of benefits)

Employer Information If retired, specify name of employer providing benefits: Employer Name: _____ Retired? <input type="checkbox"/> Address: _____ Phone: _____	Spouse's Name: _____ Spouse's Date of Birth: _____ <small>MM/DD/YEAR</small> Spouse's Employer: _____ Retired? <input type="checkbox"/> Address: _____ Phone: _____
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Please indicate all other insurance coverage you have through any other insurer: (i.e. employee/retiree/spousal group benefits, enhanced credit cards, personal property such as home/auto or any other purchased travel plan). Attach an additional page if required.

1) Name of Insurer: _____ Address: _____ Policy #: _____ Certificate #: _____	Phone: _____ Lifetime payable limit on policy? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify) \$ _____ Signature of Policyholder: _____
2) Name of Insurer: _____ Address: _____ Policy #: _____ Certificate #: _____	Phone: _____ Lifetime payable limit on policy? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify) \$ _____ Signature of Policyholder: _____

If trip purchased by **Credit Card**, specify card name: _____ Number: _____ Expiry: _____
 Have these bills been filed with any other company? No Yes If yes, name and contact info: _____

Additional documentation that IS REQUIRED (check if including)
 Original, itemized medical bills and prescription receipts if received by patient
 Photocopy of patient's Provincial Health Card

Additional documentation that MAY BE REQUIRED
 Accident Report (if applicable)
 Completed Provincial Health claim forms (only required if you are a resident of British Columbia or Newfoundland)
 Proof of Departure (envelope enclosed if required by your plan)

MEDICAL INFORMATION – (Complete only if you did not contact Mondial Assistance at the time of medical emergency)

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.

Name of Hospital or treating facility: _____ Date of Occurrence: _____

MM/DD/YEAR

Have you had any of these conditions before? Yes No

Date medications **last** changed **before** your departure (includes type and dosage): _____

MM/DD/YEAR

Name, Address and Phone # of your Family Physician: _____

Last medical visit (in Canada) before your trip? _____ Country where claim occurred: _____

MM/DD/YEAR

Have you paid for treatment? Yes No If "Yes", please specify: Partial or Paid in Full and submit proof of payment

Total amount being claimed: \$ _____ Currency: _____

AUTHORIZATION

SPECIAL DIRECTION FOR GOVERNMENT HEALTH INSURANCE PLAN AND OTHER INSURANCE COVERAGE

I direct and authorize my provincial government health insurance plan (GHIP), including OHIP, to make a payment in respect of my claim for out-of-country health services to World Access Canada, doing business as Mondial Assistance, directly and I hereby release GHIP, upon payment to World Access Canada from any further claim or cause of action in connection herewith.

I hereby consent and authorize GHIP, including OHIP, to directly or indirectly collect and use personal information including personal health information related to payment of my claim for out of country services (pursuant to Section 39 (1) of the Freedom of Information and Protection of Privacy Act, and for Ontario residents pursuant to the Health Insurance Act and the Personal Health Information Protection Act).

I consent to the disclosure by GHIP, including OHIP, to World Access Canada of such personal information including personal health information that is related to the processing and payment of my claim for out-of-country health services, including the details of any duplicate payment previously made directly to me. I understand that I may withhold my consent to the collection, use, disclosure of such information, however, if I do so my claim cannot be processed and paid. In consideration of payment 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 World Access Canada or, if directed by World Access Canada, to the insurance company underwriting the policy for which such payment was made.

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

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

I authorize any physician, hospital or other medical provider who has attended or examined me to release to and exchange with Mondial Assistance or its representatives any and all information 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 Mondial Assistance or its representatives any medical or benefits payment information relating to this claim.

I understand that if I am a dependant under this plan, the policyholder will have access to information about me related to this claim in connection with 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/YEAR

Canadian Address: _____

Signature of Patient / Designated Legal Proxy *: _____ Phone #: _____

* 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.) the provincial health plan requires proof of "Legal Representative" status.

**When sending original documents, be sure to keep a copy for your records.
If you have questions, please call us at 1-800-363-1835. Our Customer Service Team can help.**

About the documentation we require to process your claim...

Once your emergency is over (and, we hope, you're feeling better), we will be sending you claim forms to complete and will require a completed and signed EMERGENCY MEDICAL EXPENSE CLAIM FORM to process your claims payment. This form will allow us to confirm the medical expenses you incurred during your trip and, in most cases, will complete the information we require to process your claim.

Please note that we will require a completed claim form for each insured person submitting a claim. If you are signing on behalf of the patient and are not their legal guardian, the patient's Provincial Health Plan requires us to obtain proof of "Legal Representative" status.

- **PATIENT INFORMATION SECTION:** This section allows us to effectively and efficiently identify the insured member and the policy which they hold. The information in this section is essential to verifying that your coverage is current and valid.
- **TRAVEL DETAILS SECTION:** This section is required to verify that your trip and medical emergency are within the allotted timelines based on the guidelines of your policy.
- **OTHER INSURANCE INFORMATION SECTION:** This completed section of your claim form will allow us to coordinate medical payments with any other insurance plans that you may have in addition to this plan. If you also have insurance coverage with a credit card provider, your credit card number will only be used by us for the purpose of co-ordination of benefits on your insurance coverage. Otherwise, please do not provide us with your credit card number.
- **MEDICAL INFORMATION SECTION:** If for reasons beyond your control, you are unable to contact the Medical Emergency Hotline at the time of your emergency, this section gives us a brief synopsis of the situation that incurred. This section is not required to be completed if you contacted Mondial Assistance within the 48 hour period of your emergency. The reason is that upon contacting Mondial Assistance within this time frame, we will medically monitor your case in real time. Therefore, we will already possess this information and arrange billing with the medical provider.
- **AUTHORIZATION SECTION:**
 - **SPECIAL DIRECTION FOR GOVERNMENT HEALTH INSURANCE PLAN AND OTHER INSURANCE:** This section allows us to submit to your Provincial Health Plan or Other Insurance plans all eligible medical expenses that Mondial Assistance has guaranteed or paid on your behalf. Should you receive payment from the Provincial Health Plan for bills that were paid by Mondial Assistance on your behalf, you agree to send this payment to us. Coordination with your provincial plan is not optional, it is a requirement of eligibility for your travel coverage.
 - **CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION:** This signed release allows us to access your personal medical information that is related to the claim, when required, in order to help expedite the adjudication process of your claims. This is in accordance with the Personal Information Protection and Electronic Documents Act (PIPEDA).

Depending on the nature of your claim, we may require additional documentation. For example, if your medical emergency was the result of a motor vehicle accident we will require a copy of the police or accident report.

If you have personally received or paid medical bills related to this claim, you will be asked to forward the original itemized bills to our office. Photocopies or paid receipts without detailed information of each claim are not sufficient.

We suggest you keep a photocopy of all bills and all correspondence with our office for your records. Should you have any further questions regarding your claim, please contact our Claims Customer Service Department at 1 800 363 1835.