

CLAIM FORM



GlobalExcel®

Policy No. _____

Claim No. _____

Send your completed form to:

In CANADA: Global Excel Management Inc., 73 Queen Street, Sherbrooke, QC J1M 0C9 / In U.S.A.: Global Excel Management Inc., P.O. Box 10, Beebe Plain, VT 05823

IMPORTANT: Failure to sign both sides of this form will result in a delay of the processing of your claim.

SECTION A CLAIMANT INFORMATION (Please print)		
PATIENT'S INFORMATION		POLICYHOLDER'S INFORMATION
Last	First	Initial
<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of birth (M/D/Y) ____/____/____
Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Check if child is full-time student		Address (number & street) _____ Date of birth (M/D/Y) ____/____/____
Provincial health number		City _____ Province _____ Postal code _____ Home: () _____ Work: () _____
Family physician & all other physicians consulted within the ninety days prior to the date of departure		Diagnosis of illness or injury (while out of country)
Country where claim occurred		Date of incident (M/D/Y) _____ Currency _____
Trip date (M/D/Y) From: ____/____/____ To: ____/____/____	For trips exceeding 182 days, please provide proof of provincial health insurance extension.	Please indicate on each bill whether you have paid it or not.

SECTION B OTHER INSURANCE INFORMATION		
Patient's (or parent's) occupation	<input type="checkbox"/> Full-time employment <input type="checkbox"/> Retired	<input type="checkbox"/> Self-employed <input type="checkbox"/> Other: _____
<input type="checkbox"/> Student		
Name of your employer: _____		
Address: No. _____ Street _____ Suite No. _____ City _____ Province _____ Postal code _____ Telephone () _____		
Name of spouse's employer: _____		
Address: No. _____ Street _____ Suite No. _____ City _____ Province _____ Postal code _____ Telephone () _____		
Employee group benefits plan <input type="checkbox"/> Yes <input type="checkbox"/> No Group policy no. _____ Name of covered person _____ Identification no.: _____ Name of insurance company: _____ Date of birth of insured (M/D/Y): _____		
Credit card coverage <input type="checkbox"/> Yes <input type="checkbox"/> No Credit card no.: _____ Card type / bank _____ Name of the cardholder _____		
Any other coverage (e.g., union, pensioner, private or other policy purchased prior to your departure) <input type="checkbox"/> Yes <input type="checkbox"/> No Policy no. _____ Name and address of insurance company / broker: _____		
Are you covered by US Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No Plan No.: _____ Type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> Both		

AS INDICATED IN YOUR POLICY, YOUR TRAVEL INSURANCE PLAN PROVIDES COVERAGE IN EXCESS OF YOUR PROVINCIAL HEALTH INSURANCE PLAN AND ANY OTHER APPLICABLE INSURANCE. FOR GLOBAL EXCEL MANAGEMENT INC. TO SEEK REIMBURSEMENT FROM THESE SOURCES, YOU MUST COMPLETE THE FOLLOWING SECTIONS.

SECTION C AUTHORIZATION TO PHYSICIANS, HOSPITALS, AND OTHER MEDICAL PROVIDERS	
1. I, the undersigned, hereby authorize any hospital, physician, or medical facility to send my medical information to Global Excel Management Inc., authorized representatives of the insurer. I further consent to the disclosure of this information by Global Excel Management Inc. to other sources as may be required to obtain benefits from other sources.	these sources to forward payment to Global Excel Management Inc. with regard to these losses.
2. I, the undersigned, hereby assign to Global Excel Management Inc. any benefits obtainable from other sources for covered losses under this policy. I also direct	3. I warrant that neither I nor any Insured Person have any additional coverage through any other insurer (other than that listed above).
4. I understand that my insurance shall be void if, whether before or after the loss, any person has concealed or misrepresented any fact or circumstance concerning this claim.	4. I understand that my insurance shall be void if, whether before or after the loss, any person has concealed or misrepresented any fact or circumstance concerning this claim.
Claimant's or authorized person's signature _____ Date _____	

FOR COMPANY USE ONLY	Fraud Verification A: _____	Fraud Verification B: _____
----------------------	-----------------------------	-----------------------------

AGREEMENT AND AUTHORIZATION TO PROVIDE HEALTH INFORMATION

BETWEEN Patient's Full Name _____
("the Resident")

AND Global Excel Management Inc. ("GEM")

AND Her Majesty the Queen in the Right of the Province
of Alberta as Represented by the Minister of Health ("the Minister")

WHERE AS the Resident is eligible for Health Services and as such may receive payment for Health Services from the Minister.

WHERE AS the Resident is under an obligation pursuant to an insurance contract with GEM to remit to GEM all such payments received for Health Services from the Minister.

WHERE AS the Resident may be indebted to the Minister for Health insurance premiums under the Health Insurance Premiums Act, R.S.A. 2000, c.H-6 (as amended).

IN CONSIDERATION of the undertakings provided herein, the parties agree:

1. Subject to clause 2, the Resident assigns to GEM all sums of money that shall be owing to the Resident by the Minister for the above noted contract. The Minister is authorized to pay all such sums directly to GEM, with payment of any such sum to be sufficient discharge to the Minister of and from any indebtedness in that amount to the Resident, his heirs, executors, or administrators.
2. Prior to any payment being made by the Minister to GEM, the Minister is authorized by the Resident to deduct from the sums payable to GEM, any amount for which the Resident is indebted to the Minister for arrears in health insurance premiums owing under the Health Insurance Premiums Act.
3. This Agreement is effective from _____ to _____
(Departure date) (Return date)

I further hereby consent to and authorize the Minister of Health and Alberta Blue Cross (Coverage for Seniors) to furnish to any representative of Global Excel Management Inc., such records and information as may be disclosed in accordance with the Alberta Health Care Insurance Act, regarding claims for Health Services incurred while I had insurance coverage on the dates above-listed regardless of elapsed time. I also authorize Alberta Blue Cross (Coverage for Seniors) to coordinate benefits with Global Excel Management Inc.

DATED this _____ day of _____, 20 _____.

Alberta Personal Health Card Number

SIGNATURE

Telephone Number

Address

Important: **Accurately completing all details will assist us in settling your claim promptly.** Please attach original bills or receipts when submitting your claim. We recommend you keep copies for your own records.

 For Claim inquiries, call **1-800-336-9224** or **819-566-8698**.

Please complete the other side of this form.