

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	Last	First	Initial
<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of birth (M/D/Y) ____/____/____	Address (number & street)		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			City		Province Postal code
Provincial health number			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"/> Self-employed	<input type="checkbox"/> Student
	<input type="checkbox"/> Retired	<input type="checkbox"/> Other: _____	
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	
<p>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.</p> <p>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</p>	<p>these sources to forward payment to Global Excel Management Inc. with regard to these losses.</p> <p>3. I warrant that neither I nor any Insured Person have any additional coverage through any other insurer (other than that listed above).</p> <p>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.</p>
<p>Claimant's or authorized person's signature _____ Date _____</p>	

FOR COMPANY USE ONLY	Fraud Verification A: _____	Fraud Verification B: _____
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SCHEDULE "A"
AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

I, _____ (or, I _____ parent/guardian of _____, a minor) hereby consent to and authorize Manitoba Health to furnish to any representative of _____, claim and payment information in Manitoba Health's possession in respect of claims for Medical Services incurred for which I had insurance coverage from _____ including physician/hospital name, date of service, and services provided (in-patient, out-patient, physiotherapy, visit, procedure, x-ray or laboratory services).

ASSIGNMENT OF PAYMENT DUE TO REGISTRANT UNDER THE HEALTH SERVICES INSURANCE ACT

I, _____ (or, I _____ parent/guardian of _____, a minor) hereby direct Manitoba Health to forward payment to _____, for any claims for benefits under the Health Services Insurance Act submitted by _____ in respect for medical and hospital services provided outside Canada.

DATED this _____ day of _____, 20____

_____	_____
Manitoba Health Registration Number	SIGNATURE

	Address

_____	_____
Personal Health Identification Number	Telephone

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