

# 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 212 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	
<b>Patient's (or parent's) occupation</b>	<input type="checkbox"/> Full-time employment <input type="checkbox"/> Self-employed <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Other: _____
<b>Name of your employer:</b> _____	
<b>Address:</b> No. _____ Street _____ Suite No. _____ City _____ Province _____ Postal code _____ Telephone ( ) _____	
<b>Name of spouse's employer:</b> _____	
<b>Address:</b> No. _____ Street _____ Suite No. _____ City _____ Province _____ Postal code _____ Telephone ( ) _____	
<b>Employee group benefits plan</b> <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): _____	
<b>Credit card coverage</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Credit card no.: _____ Card type / bank _____ Name of the cardholder _____	
<b>Any other coverage (e.g., union, pensioner, private or other policy purchased prior to your departure)</b> <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.
<b>Claimant's or authorized person's signature</b> _____ <b>Date</b> _____	

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

# Appendix A — Authorization and Release Specifications

## 1. DIRECTION AND RELEASE

I, \_\_\_\_\_ personally or as the authorized substitute/proxy for \_\_\_\_\_ (the Insured Patient) irrevocably direct and authorize the Ontario Ministry of Health and Long-Term Care ("the Ministry") to make payment in respect of my claim, or if applicable, the Insured Patient's claim, for out-of-country health services directly to Global Excel Management Inc. ("GEM") and hereby release the Ministry, upon payment to GEM, from any further claim or cause of action in connection therewith.

**Note: An authorized substitute/proxy is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**

## 2. CONSENT

**I authorize the Ministry to collect my/insured patient's personal health information, consisting of:**

- information relating to my/insured patient's receipt of health care services outside of Canada, and
- information relevant to the reimbursement of those services under the Health Insurance Act, R.S.O. 1990, c. H.6

from GEM, and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying my/insured patient's request for payment under the Health Insurance Act, including the details of any duplicate payment previously made to me/insured patient, to GEM.

I understand the purpose for the Ministry's collection and disclosure of this personal health information.

You have the right to refuse to sign this consent form, however, GEM and the Ministry will be unable to process your/insured patient's claim if this form is unsigned.

## 3. AUTHORIZATION

My/Insured Patient's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone.: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### YOUR/INSURED PATIENT'S

**ONTARIO HEALTH INSURANCE NUMBER:** \_\_\_\_\_ **YOUR/INSURED PATIENT'S VERSION CODE\*:** \_\_\_\_\_

Witness Name: \_\_\_\_\_ Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone.: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

\* Depending on the date your/insured patient's Ontario Health Card was issued or renewed, your/insured patient's **VERSION CODE** may be two letters, one letter, or you/insured patient may not yet have a **VERSION CODE**.

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

**Please complete the other side of this form.**