

# CLAIM FORM



GlobalExcel®

Policy No. \_\_\_\_\_

File 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		City	Province    Postal code
<input type="checkbox"/> Check if child is full-time student		Home: (    )    Work: (    )	
Provincial health number		Diagnosis of illness or injury (while out of country)	
Family physician & all other physicians consulted within the ninety days prior to the date of departure		Date of incident (M/D/Y)	Currency
Country where claim occurred		____/____/____	
Trip date (M/D/Y)		Please indicate on each bill whether you have paid it or not.	
From: ____/____/____ To: ____/____/____		For trips exceeding 212 days, please provide proof of provincial health insurance extension.	

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"/> Retired	<input type="checkbox"/> Student
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	
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).
Claimant's or authorized person's signature _____	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.
	Date _____

FOR COMPANY USE ONLY	Fraud Verification A: _____	Fraud Verification B: _____
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# Appendix A — Authorization and Release Specifications Involving a Minor

## 1. DIRECTION AND RELEASE

I, \_\_\_\_\_ personally or as the authorized custodial parent 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/the insured patient's personal health information, consisting of:**

- information relating to my/the 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/the insured patient's request for payment under the Health Insurance Act, including the details of any duplicate payment previously made to my/the 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/the insured patient's claim if this form is unsigned.

## 3. AUTHORIZATION

Custodial Parent Name: \_\_\_\_\_

My/The 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 settling your/the insured patient's claim promptly.**

Please attach original bills or receipts when submitting your/the insured patient's claim. We recommend you keep copies for your own records.

\* Depending on the date your/the insured patient's Ontario Health Card was issued or renewed, your/the insured patient's **VERSION CODE** may be two letters, one letter, or you/the 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** ❖❖❖❖