

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) ____/____/____	Address (number & street) _____ _____ _____
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"/> Retired	<input type="checkbox"/> Student
	<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	
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.
Claimant's or authorized person's signature _____ Date _____	

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

SCHEDULE "A"

ASSIGNMENT OF PAYMENT DUE TO BENEFICIARY UNDER THE SASKATCHEWAN MEDICAL CARE INSURANCE ACT OR THE SASKATCHEWAN HOSPITALIZATION ACT

BETWEEN _____ of the first part, (the **Assignor**)
(Claimant name)

AND Global Excel Management Inc. of the second part, (the **Assignee**)

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

WHERE AS the Assignor is a person eligible for medical services under Saskatchewan Medical Care Insurance Act or the Saskatchewan Hospitalization Act or both, and as such may receive payment for the above services from the Minister.

WHERE AS the Assignor is under covenant or obligation under a contract of insurance with the assignee to remit to the Assignee to remit to the Assignee all such payments received for medical services from the Minister.

NOW WITNESS THAT in consideration of the said obligation to the Assignee the Assignor hereby assigns unto the Assignee all sums of money that shall be owing to the assignor by the Minister for the above noted contract. The Minister is hereby authorized to pay all such sums directly to the Assignee at the address aforesaid, or at any address the Assignee may from time to time designate, his heirs, executors, or administrators.

DATED this _____ day of _____, 20_____.

SIGNATURE OF ASSIGNOR

Witness:

Assignment:
Effective from: ____ / ____ / ____ to ____ / ____ / ____
(travel dates) M D Y M D Y

Signature

Occupation

SCHEDULE "B"

AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

I, _____ hereby consent to and authorize the department of Health to furnish to any representative of Global Excel Management Inc., claim and paymnet information in the Department of Health,s possession in respect of claims for Medical Services incurred while I had insurance coverage from ____ / ____ / ____ to ____ / ____ / ____
M D Y M D Y

including payment and claim information for the period within 6 months prior to the date of service of the aforementioned Medical Services including physician/hospital name, date of service, and service profided (in-patient, out-patient, visit, procedure, x-ray or laboratory service or other medical treatment).

DATED this _____ day of _____, 20_____.

Personal Health Number

SIGNATURE

Address

Telephone

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