

IMPORTANT NOTICE

A duly completed and signed claim form is necessary even if you haven't made any payments. Your public health insurance plan covers some of the fees for medical care received during your trip. CanAssistance reimburses these fees in full, but must submit them to your provincial health insurance plan.

According to the terms of your contract, by signing the form you authorize CanAssistance to:

- Access your personal and medical information required to adjudicate your claim
- Pay eligible expenses to service providers directly

Failure to return this duly completed form entitles CanAssistance to ask you to refund the fees paid on your behalf.

Filing a Claim

Complete the claim form(s) and sign where designated with an X.

- Each person who received healthcare services must complete a claim form.
- The form must be signed by the beneficiary (person who received healthcare services). If the claim involves a minor, the policyholder must sign the form.



Attach all the following documents:

- Original itemized bills for all healthcare services received, the diagnosis and treatment must appear clearly.
- Original prescription drug receipts showing the name of the drug, the dosage and the price.
- Proof of payment for all expenses claimed, such as a credit card statement or proof of a deposited cheque, showing the currency in which the service was paid. In the absence of a bank or credit card statement, a receipt may be accepted.
- Proof of your departure and return dates, such as a plane ticket, a stamped copy of your passport or a bank or credit card statement showing purchases made in Canada just before your departure date and immediately after your return.
- Any other relevant document(s), such as medical reports, lab results, etc.



We recommend you keep a copy of your claim documents for record-keeping purposes, as they will not be returned.



Send this duly completed forms and all other required scanned documents online via our secure website:

canassistance.com/en/policyholder/depot

We reserve the right to request the original documents up to one year from the date of submission of your claim.

You can also send forms and original claim documents by mail to:

CanAssistance
Travel Claims Departement
PO BOX 3888, Station B
Montreal, Quebec, H3B 3L7

Additional Information

Your claim will be reviewed as quickly as possible once we've received the required documents. The following situations may increase the time it takes us to process your claim:

- An incomplete claim form or missing document
- Delayed or missing detailed invoice
- Delayed or missing medical information

Eligible expenses are reimbursed in Canadian funds by cheque made out to the policyholder. If you're covered by more than one travel insurance policy, indicate this on your claim form. We will work with your other insurer to coordinate your benefits as needed.

If you receive a bill, please do not make any payments directly to the service provider unless we instruct you to do so. Simply send it to the address above.

Should you have any questions about your claim, please contact us by using the phone number on your insurance card or visit our website at canassistance.com.

CLAIM PROCESS

- A. Fill out the insurer's name and the contract or certificate number. If available, you can fill out the group number and the file number.
- B. Complete both sides and **SIGN THE CLAIM FORM**.
- C. Indicate your Manitoba Health number to avoid delays in processing.
- D. Keep a copy of all documents for your records and send them online via our secure website: canassistance.com/en/policyholder/depot
 Or by mail to: **CANASSISTANCE - TRAVEL CLAIMS DEPARTMENT**
PO BOX 3888, STATION B
MONTREAL, QUEBEC, H3B 3L7

INSURANCE COMPANY	(Optional) GROUP NUMBER
CONTRACT, CERTIFICATE OR IDENTIFICATION NUMBER	(Optional) FILE NUMBER

MANDATE

1. I, the undersigned (please print) _____
 (or, I _____ parent/guardian of _____, a minor) hereby:

A. consent to and authorize Manitoba Health to furnish to any representative of Canassurance Hospital Service Association and CanAssistance Inc. claim and payment information in Manitoba Health's possession in respect of claims for Medical Services incurred during my coverage period (in accordance with my travel insurance policy) including physician/hospital name, date of service, and services provided (in-patient, out-patient, physiotherapy, visit, procedure, X-ray or laboratory services).

B. direct Manitoba Health to forward payment to Canassurance Hospital Service Association and CanAssistance Inc. for any claims for benefits under the Health Services Insurance Act submitted by Canassurance Hospital Service Association and CanAssistance Inc. in respect of medical and hospital services provided outside Manitoba.

2. I hereby consent and authorize Canassurance Hospital Service Association and CanAssistance Inc. to directly or indirectly collect information contained in the claim and source documents pursuant to applicable provincial legislation.

3. I hereby agree to assign to Canassurance Hospital Service Association and CanAssistance Inc. all benefits payable by third parties for losses covered under the policy. Furthermore, following the application for reimbursement from Canassurance Hospital Service Association and CanAssistance Inc., I authorize third parties to pay Canassurance Hospital Service Association and CanAssistance Inc., the benefits payable regarding these losses.

4. I authorize Canassurance Hospital Service Association and CanAssistance Inc. to provide the information contained in my claim file to third parties, for their use, within the context of this claim, to determine the benefits payable, if the case arises.

5. I certify that the information contained herein is true and complete to the best of my knowledge and I hereby authorize any licensed physician, practitioner, hospital or medical institution, insurance company, the Medical Information Bureau or any other agency, institution or person who has information or documents about me or a member of my family, or my state of health or that of a member of my family (including all previous medical reports) to convey that information or forward those documents to Canassurance Hospital Service Association and CanAssistance Inc.

X

SIGNATURE OF THE BENEFICIARY

DATE

If not the beneficiary, relationship (father, mother, etc.): _____

A photocopy or a fax of this authorization shall be considered as valid as the original.

BENEFICIARY

MANITOBA HEALTH REGISTRATION NUMBER (6 digits)	LAST NAME (as it appears on Manitoba Health card)		FIRST NAME (as it appears on Manitoba Health card)		
PERSONAL HEALTH IDENTIFICATION NUMBER (9 digits)	DATE OF BIRTH Year Month Day	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	TELEPHONE - HOME		CELL

PLEASE COMPLETE AND SIGN THE BACK OF THIS FORM

CLAIM FORM – TRAVEL INSURANCE



POLICYHOLDER (IF DIFFERENT FROM THE BENEFICIARY)

LAST NAME (as it appears on Manitoba Health card)	FIRST NAME (as it appears on Manitoba Health card)	DATE OF BIRTH <small>Year Month Day</small>	FOR OFFICE USE GENDER <input type="checkbox"/> M <input type="checkbox"/> F
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POLICYHOLDER DETAILS

NAME OF THE EMPLOYER			
1	Home address in Manitoba <small>No STREET Apt.</small>	POSTAL CODE	TELEPHONE
2	Address for correspondence or payment (if different) <small>No STREET Apt.</small>	POSTAL CODE	TELEPHONE
3	E-MAIL:		CELL
SEND CHEQUE TO: <input type="checkbox"/> ADDRESS 1 <input type="checkbox"/> ADDRESS 2 SEND CORRESPONDENCE TO: <input type="checkbox"/> ADDRESS 1 <input type="checkbox"/> ADDRESS 2			

STAY OUTSIDE MANITOBA

Trip during which you received healthcare services.					
Date of departure <small>Year Month Day</small>	Actual <small>Year Month Day</small>	Date of return to Manitoba <small>Planned (if different) Year Month Day</small>			
Reason for trip (check one box only)					
<input type="checkbox"/> Vacation or seasonal absence					
<input type="checkbox"/> Work Employer's name: _____					
<input type="checkbox"/> School Include a written certificate from the institution indicating the start and end dates of your courses.					
<input type="checkbox"/> Receive medical care If you requested authorization from Manitoba Health, indicate the authorization number: _____					
<input type="checkbox"/> Other Specify: _____					

REIMBURSEMENT

Amount claimed:
Currency: <input type="checkbox"/> Canadian dollars <input type="checkbox"/> Other currency (specify): _____
Were bills paid? <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, please specify: <input type="checkbox"/> Totally <input type="checkbox"/> Partially: _____ Paid amount

HEALTHCARE SERVICES OUTSIDE MANITOBA

Indicate why you received healthcare services.	
In the case of an accident, specify the type of accident: <input type="checkbox"/> Motor vehicle accident <input type="checkbox"/> Work related <input type="checkbox"/> Other (specify): _____	
Date of the accident <small>Year Month Day</small>	Date of the accident <small>Year Month Day</small>
Describe the services received (e.g.: tests, X-rays, surgery, etc.). If necessary, continue on a separate piece of paper. _____ _____ _____	
Where did you receive these services? City _____ Canadian province or U.S. state _____ Country _____	
If applicable, indicate the number of days you were hospitalized: _____	

HEALTHCARE SERVICES IN MANITOBA

If you consulted a doctor or a specialist during the last 6 months prior to your trip, specify: Name: _____ Address: _____ Nature of illness: _____ Date of last visit: <small>Year Month Day</small>	If you were hospitalized in Manitoba during the last 6 months prior to your trip, specify: Nature of illness: _____ Name and address of hospital: _____ _____ _____ File Number: _____
List all medication(s) taken in the 6 months prior to your trip: _____	

OTHER INSURANCE

Please list below all your other travel insurance coverage			
Group Insurance: _____ <small>Name of the insurance company</small>	Policy No: _____	Certificate No: _____	
Bank credit card: _____ <small>Name of the financial institution</small>	Card No: _____	X X X X X	
Other travel insurance: _____			

PLEASE COMPLETE AND SIGN THE FRONT OF THIS FORM

IMPORTANT NOTICE

If your claim is deemed admissible, by default a cheque will be sent to the policyholder. If you prefer to receive the reimbursement in your chequing account through direct deposit, please complete this form and attach a voided cheque.

We recommend that you select direct deposit for a number of reasons:

- Avoid the many possible days that come with receiving cheques by mail.
- Access your funds immediately without any holds that may be required by your financial institution.

SEND THIS DULY COMPLETED FORM ALONG WITH ALL OTHER REQUIRED DOCUMENTS TO CANASSISTANCE

Online via our secure website:

canassistance.com/en/policyholder/depot

Send all scanned documents and keep originals. We reserve the right to request the original documents up to one year from the date of submission of your claim.

By regular mail:

CanAssistance, Travel Claims Department
PO BOX 3888, Station B, Montreal, Quebec, H3B 3L7

Policyholder identification

Name of the policyholder

Contract, certificate or identification number

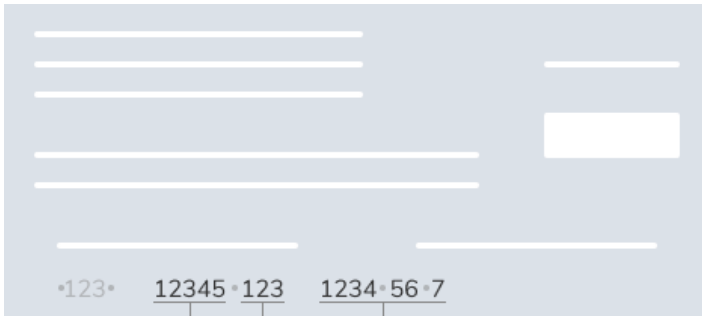
File number

Bank Account Details (Canadian financial institutions only)

To avoid payment errors and delays, please attach a voided cheque. A copy can also be obtained through the online banking services of your financial institution.

Scan the document or take a photo of it, making sure all information is legible.

If you are unable to provide a voided cheque, please carefully complete the sections below.



Branch number _____

Institution number _____

Account number _____

1 - Transit (Branch) Number 2 - Financial Institution Number 3 - Account Number

I hereby request that my benefits be paid via electronic funds transfer (direct deposit) to the aforementioned account number.

Signature of the policyholder _____ Date _____