

CLAIMS PROCESS

- A. Complete both pages of this form.
- B. Sign the « Assignment of Benefits » section if applicable.
- C. Sign the « Agreement and Authorization » section. If the beneficiary is a minor, a parent or legal guardian must sign the form.

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

INSURANCE COMPANY	GROUP NUMBER (Optional)
CONTRACT NUMBER	FILE NUMBER (Optional)

Policyholder

Last name		First name		Date of birth Year Month Day			Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Email				Telephone 1			Telephone 2	
Country of origin				Relationship to beneficiary (if different from policyholder)				
Address in Canada no Street		Apt.		City			Province Postal Code	
Assignment of benefits								
Are eligible benefits payable to a person other than the policyholder? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify who the cheque should be issued to.								
Name and address of the person: _____								
								Signature of policyholder _____

Beneficiary (if different from policyholder)

Last name		First name		Date of birth Year Month Day			Gender <input type="checkbox"/> M <input type="checkbox"/> F	
-----------	--	------------	--	-------------------------------------	--	--	-----------------------------------------------------------------	--

Information about your trip

Stay in Canada			Reason for trip						
Arrival date in Canada Year Month Day		Departure date from Canada Year Month Day		<input type="checkbox"/> Vacation <input type="checkbox"/> Immigration <input type="checkbox"/> Studies, name of institution: _____ <input type="checkbox"/> Work, name of employer: _____ <input type="checkbox"/> Other, specify: _____					
Stay in the U.S.									
Departure date from Canada Year Month Day		Return date to Canada Year Month Day							

Agreement and Authorization

1. I hereby agree to assign to Canassurance Hospital Service Association and CanAssistance Inc. (hereinafter called the Insurer) all benefits payable by third parties for losses covered under the policy. Furthermore, following the application for reimbursement from CanAssistance Inc., I authorize third parties to pay CanAssistance Inc., the benefits payable regarding these losses.
2. I authorize the Insurer 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.
3. I authorize the Insurer to make payments pertaining to the expenses claimed, directly, when required, to any institution and/or any other provider of services.
4. To assess my application for benefits, I authorize any licensed physician, practitioner, hospital or medical institution, insurance company, or any other agency, institution or person, who have information necessary to analyze my application, to convey that information to the Insurer. I understand that said information may be disclosed when required to its reinsurers, to internal and external auditors and to any professional or organization mandated by the Insurer within the context of processing my application for benefits. This authorization is valid until the final settlement of my claim.
5. I declare that the information and details given on this form and the information provided in the attached documents are complete and true, and I am aware that any false declaration shall nullify the insurance certificate or insurance policy and shall result in the denial of my application for benefits.
6. By sending us this form, you understand that we will process your personal information in accordance with the terms of our Privacy Policy. We invite you to read our Privacy Policy available on our web site, which provides, without limitation, information about the categories of third parties to whom it is necessary to communicate your personal information, sometimes outside your province of residence, and your rights to access and correct your personal information.

Signature of Policyholder or legal heir: _____ Date : _____

Signature of Beneficiary (if different from policyholder): _____ Date : _____

CLAIM FORM – VISITORS TO CANADA



FOR OFFICE USE

Services and care received

Date when first symptoms appeared or accident occurred City and country where services were received

Year | Month | Day

Indicate the reason why you received medical and/or hospital care

Describe services received (e.g.: examination, x-ray, surgery, etc.). Please use a separate sheet if needed.

If claiming due to an accident, please specify:

Date of accident Type of accident

Year | Month | Day

Motor vehicle Work Other, specify: _____

Amount Claimed

Amount claimed: _____

Currency:

Canadian Dollars

Other, specify: _____

Were bills paid?

Yes

No

If yes, please specify:

Totally

Partially _____

Paid amount

Other Insurance

Do you, your spouse or child have another travel insurance Yes No If yes, please provide the following information:

Policyholder _____ Insurance Company _____

Policy number _____ Company phone number _____

Identification number _____

Have you already initiated a claim? Yes No If yes, please indicate the file number: _____

Medical Information

If the beneficiary consulted a doctor or specialist in the 6 months preceding the effective date of the policy, please provide:

Physician name / Medical Facility	Telephone / Email	Nature of the illness or accident	Date of service

If the beneficiary was hospitalized in the 12 months preceding the effective date of the policy, please provide:

Hospital name	Telephone / Email	Nature of the illness or accident	Admission date
			Year Month Day
Address (city and country)			Discharge date
			Year Month Day

Please provide the names of all the medicines the beneficiary was taking in the 6 months preceding the effective date of the policy:

Essential Documents to Submit

- This duly completed and signed form.
 - If more than one person received care, you will need to complete a claim form for each person.
 - If the claim involves a person who is a minor, the policyholder or legal heir must sign the form.
- The detailed invoices and proof of payment.
 - Invoices for medical care must show the diagnosis and treatment.
 - Invoices related to the purchase of prescription medication must show the name of the drug, the dosage and the price.
 - Valid proof of payment may include a credit card statement or proof of a deposited cheque, and the currency in which the service was paid must appear. In the absence of a bank or credit card statement, a receipt may be accepted.
- Any other relevant document(s), such as medical reports, lab results, etc.

An incomplete claim may cause additional delays in processing your file. If you can't submit all requested documents, please provide us with an explanation in a letter attached to your claim. We reserve the right to request the original documents or additional information if needed. Please keep a copy of your supporting documents for your records.

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.

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

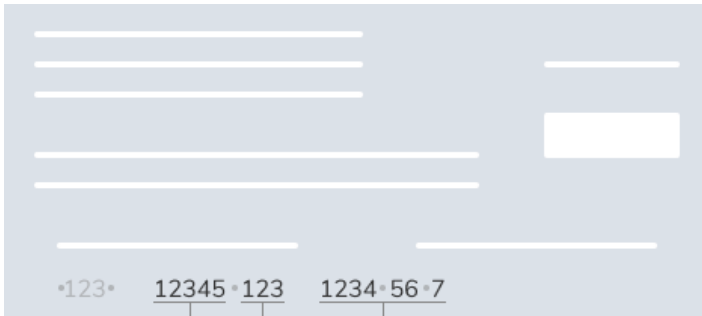
File number

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 _____