can assistance

CLAIM FORM – TRAVEL INSURANCE

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.

01CAB0031A (2022-08)

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TRAVEL INSURANCE CLAIM FORM

CONTRACT, CERTIFICATE OR IDENTIFICATION NUMBER

POLICY OR GROUP NUMBER (OPTIONAL)

BENEFICIARY INFORMATION (please complete a separate form for each person)

PROVINCIAL HEALTH NUMBER

LAST NAME

LAST NAME AT BIRTH (if different)

FIRST NAME

DATE OF BIRTH YEAR MONTH DAY

SEX ☐ M ☐ F

PERMANENT ADDRESS IN CANADA

POSTAL CODE

TELEPHONE NO. HOME AREA CODE

WORK AREA CODE

STAY OUTSIDE CANADA/PROVINCE

DATE OF DEPARTURE YEAR MONTH DAY

DATE OF RETURN: (ACTUAL OR PLANNED) YEAR MONTH DAY

REASON FOR TRIP

☐ VACATION

☐ WORK NAME OF EMPLOYER:

☐ STUDIES INCLUDE A WRITTEN CERTIFICATE FROM THE INSTITUTION:

☐ OTHER DESCRIBE:

SERVICES AND CARE RECEIVED

INDICATE THE REASON WHY YOU RECEIVED MEDICAL OR HOSPITAL SERVICES:

DESCRIBE THE CARE RECEIVED (E.G., EXAMINATION, X-RAYS, SURGERY, ETC.) IF SPACE IS INSUFFICIENT, ATTACH ANOTHER SHEET.

CITY AND COUNTRY WHERE THE SERVICES WERE RECEIVED:

IN THE CASE OF AN ACCIDENT, INDICATE:

DATE OF THE ACCIDENT YEAR MONTH DAY

TYPE OF ACCIDENT: ☐ TRAFFIC ☐ WORK RELATED ☐ OTHER (SPECIFY):

HAVE THE BILLS BEEN PAID? ☐ YES ☐ NO **IF YES:** ☐ IN FULL ☐ PARTLY

AMOUNT PAID

CURRENCY ☐ CANADIAN DOLLARS ☐ OTHER (SPECIFY):

PLEASE LIST BELLOW ALL YOUR OTHER TRAVEL INSURANCE COVERAGE

GROUP INSURANCE / PURCHASED FROM TRIP PROVIDER **POLICY NO. :**

IF THAT COVERAGE IS FROM YOUR CREDIT CARD, PLEASE INDICATE YOUR CREDIT CARD NUMBER: X X X X X

MEDICAL INFORMATION BEFORE DEPARTURE

DOCTOR AND SPECIALIST (IF APPLICABLE) IN CANADA BEFORE DEPARTURE:

NAME ADDRESS

NATURE OF ILLNESS: DATE OF LAST VISIT: YEAR MONTH DAY

HAVE YOU BEEN HOSPITALIZED IN CANADA IN THE LAST 6 MONTHS PRIOR TO YOUR TRIP? ☐ YES ☐ NO

NATURE OF ILLNESS

NAME OF HOSPITAL CITY

ADMISSION DATE YEAR MONTH DAY FILE NUMBER:

LIST THE MEDICATION(S) YOU WERE TAKING DURING THE 6-MONTH PERIOD PRECEDING YOUR DEPARTURE:

CONSENT AND AUTHORIZATION

1. I AUTHORIZE CANASSISTANCE INC. AND ITS SIGNING OFFICERS AS MY ATTORNEYS TO RECEIVE IN MY NAME AND ENDORSE AND NEGOTIATE ON MY BEHALF, CHEQUES AND OTHER FORMS OF PAYMENT FROM MY PROVINCIAL OR TERRITORIAL HEALTH INSURANCE PLAN FOR THE REIMBURSEMENT OF CLAIMS RELATING TO HOSPITAL AND MEDICAL SERVICES INCURRED DURING A TRIP OUTSIDE MY PLACE OF RESIDENCE DURING MY COVERAGE PERIOD, INCLUDING ANY AUTHORIZED EXTENSION OF SUCH COVERAGE, AND IN ACCORDANCE WITH MY TRAVEL INSURANCE PLAN.
2. I IRREVOCABLY DIRECT AND AUTHORIZE MY PROVINCIAL OR TERRITORIAL HEALTH INSURANCE PLAN TO MAKE PAYMENT IN RESPECT OF MY CLAIM FOR HEALTH SERVICES INCURRED DURING SUCH TRIP TO CANASSISTANCE INC. DIRECTLY AND I HEREBY RELEASE MY PROVINCIAL OR TERRITORIAL HEALTH INSURANCE PLAN, UPON PAYMENT TO CANASSISTANCE INC. FROM ANY FURTHER CLAIM OR CAUSE OF ACTION IN CONNECTION THEREWITH.
3. I HEREBY CONSENT AND AUTHORIZE CANASSISTANCE INC. AND MY PROVINCIAL OR TERRITORIAL HEALTH INSURANCE PLAN TO DIRECTLY OR INDIRECTLY COLLECT INFORMATION CONTAINED IN THE CLAIM AND SOURCE DOCUMENTS PURSUANT TO APPLICABLE PROVINCIAL LEGISLATION.
4. I CONSENT TO THE DISCLOSURE BY MY PROVINCIAL OR TERRITORIAL HEALTH INSURANCE PLAN TO CANASSISTANCE INC. OF SUCH PERSONAL INFORMATION AS MAY BE NECESSARILY REQUIRED FOR THE PROCESSING OF MY CLAIM FOR SUCH HEALTH SERVICES, INCLUDING THE DETAILS OF ANY DUPLICATE PAYMENT PREVIOUSLY MADE DIRECTLY TO ME.
5. I HEREBY AGREE TO ASSIGN TO CANASSISTANCE INC. 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.
6. I AUTHORIZE 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.
7. 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, MY PROVINCIAL OR TERRITORIAL HEALTH INSURANCE PLAN, 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 CANASSISTANCE INC.

A PHOTOCOPY OF THIS AUTHORIZATION AS SIGNED BY ME, MY PARENT, GUARDIAN OR AUTHORIZED ATTORNEY SHALL BE AS VALID AS THE ORIGINAL.

SIGNATURE OF BENEFICIARY OR BENEFICIARY'S PARENT, GUARDIAN OR AUTHORIZED ATTORNEY

PRINT NAME

DATE (yy-mm-dd)

01CAB0044A (2023-03)

POLICYHOLDER (IF DIFFERENT FROM THE BENEFICIARY)

LAST NAME

FIRST NAME

AGE

PROVINCIAL HEALTH NUMBER:

TELEPHONE: HOME

WORK

CANASSISTANCE - TRAVEL CLAIMS DEPARTMENT
PO BOX 3888, STATION B, MONTREAL, QUEBEC, H3B 3L7 - CANASSISTANCE.COM/EN/POLICYHOLDER/DEPOT

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REQUEST FOR PAYMENT BY DIRECT DEPOSIT

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:	*By regular mail:*
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.	**CanAssistance, Travel Claims Department** **PO BOX 3888, Station B, Montreal, Quebec, H3B 3L7**

Policyholder identification

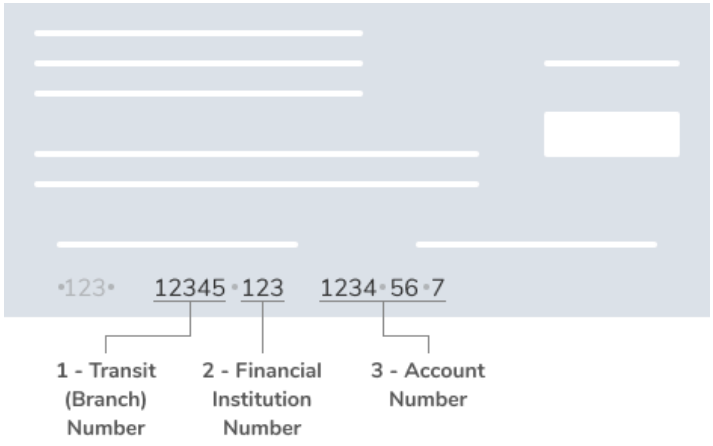
Name of the policyholder	Contract, certificate or identification number	File number

Bank Account Details (Canadian financial institutions only)

To avoid payment errors and delays, please attach a voided cheque. A copy can also been 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 _____

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

Signature of the policyholder _____ Date _____

Newfoundland Labrador
Health and Community Services

OUT-OF-PROVINCE CLAIM

mcp
Medical Care Plan

SECTION A | PATIENT INFORMATION (To Be Completed By Patient or Parent/Guardian) – PLEASE PRINT CLEARLY

Patient Surname	All Given Names	MCP Number	Card Expiry Date YYYY MM DD

Surname at Birth (if different from above)	Date of Birth YYYY MM DD	Sex ☐ Male ☐ Female	Daytime Telephone Number	Email Address

PERMANENT Mailing Address: Street / P.O. Box	City / Town	Province	Postal Code
TEMPORARY Mailing Address: Street / P.O. Box	City / Town	Province / State	Postal / Zip Code

Date of Departure From Home YYYY MM DD	Place Where Treated (Province/Territory)	Date of Arrival YYYY MM DD	Is this a Permanent Move? ☐ Yes ☐ No	Date of Return Home YYYY MM DD

Reason for Absence From Home: ☐ Vacation ☐ Business ☐ Study – Name of Institution _____ ☐ Other – Specify _____

DECLARATION
I hereby declare, conscientiously believing it to be true and knowing it to have the same effect as if it were made under oath and by virtue of the Canada Evidence Act, that the information given above is correct and that I am a beneficiary of the Newfoundland & Labrador Medical Care Plan.

Signature of Patient (or parent/guardian, if applicable): _____ Date: _____

Parent/guardian signature required if patient is less than 16 years of age. If signed by other than patient, please state relationship to patient. _____

SECTION B | PAYMENT INFORMATION

Payment should be made to: ☐ Treating physician ☐ Patient / contract holder ☐ Third party – Specify _____

Address of Third Party (if applicable): Street / P.O. Box	City / Town	Province / State	Postal / Zip Code

SECTION C | PHYSICIAN / TREATMENT INFORMATION (To Be Completed By Physician) - PLEASE PRINT CLEARLY

Physician Surname	All Given Names	Specialty ☐ Certified ☐ Non-Certified

Street / P.O. Box	City / Town	Province / State	Postal / Zip Code

Name of Referring Physician	Services Provided In: ☐ Office ☐ Home ☐ Hospital In-Patient ☐ Hospital Out-Patient

If ☐ Anesthetist ☐ Surgical Assist ☐ Psychiatrist Provide duration of service: Hours _____ Minutes _____

IF HOSPITAL SERVICES: Name of Hospital	Admission Date YYYY MM DD	Discharge Date YYYY MM DD

Street / P.O. Box	City / Town	Province / State	Postal / Zip Code

Procedure / Treatment	Fee Code	Fee	Date of Service	Duration	For Office Use Only
			YYYY MM DD		
			YYYY MM DD		
			YYYY MM DD		
			YYYY MM DD		
			YYYY MM DD		

Diagnosis and Other Remarks

Claim Involves: ☐ Workers' Compensation ☐ Pensionable Disability ☐ Automobile Accident ☐ Other Third Party	Physician's Signature	Date	Language of Correspondence ☐ English ☐ French

PLEASE PROVIDE ORIGINAL DOCUMENTATION

PRIVACY NOTICE
Personal health information collected, used, disclosed, and safeguarded is in accordance with the *Personal Health Information Act* (PHIA). If you have any questions about the collection or use of this information please contact our office. The Department of Health and Community Services privacy statement can be found at www.health.gov.nl.ca/health/PHIA.

Medical Care Plan
P.O. Box 5000, Grand Falls-Windsor, NL, Canada, A2A 2Y4
Telephone: (709)292-4000 Toll Free: 1-800-563-1557 Facsimile: (709)292-4053 http://www.gov.nl.ca/mcp