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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.

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CLAIM FORM – TRAVEL INSURANCE

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 Insurance Company 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 Insurance Company and CanAssistance Inc. for any claims for benefits under the Health Services Insurance Act submitted by Canassurance Insurance Company and CanAssistance Inc. in respect of medical and hospital services provided outside Manitoba.

2. I hereby consent and authorize Canassurance Insurance Company 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 Insurance Company and CanAssistance Inc. all benefits payable by third parties for losses covered under the policy. Furthermore, following the application for reimbursement from Canassurance Insurance Company and CanAssistance Inc., I authorize third parties to pay Canassurance Insurance Company and CanAssistance Inc., the benefits payable regarding these losses.

4. I authorize Canassurance Insurance Company 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 Insurance Company and CanAssistance Inc.

X _____ _____

SIGNATURE OF THE BENEFICIARY **DATE**

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

01CAN0120A (2024-10)

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 ☐ M ☐ F	TELEPHONE - HOME	CELL

PLEASE COMPLETE AND SIGN THE BACK OF THIS FORM

CLAIM FORM – TRAVEL INSURANCE

FOR OFFICE USE

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 (Year / Month / Day)	GENDER
			☐ M ☐ F

POLICYHOLDER DETAILS

NAME OF THE EMPLOYER

1 Home address in Manitoba — No / STREET / Apt. / POSTAL CODE / TELEPHONE

2 Address for correspondence or payment (if different) — No / STREET / Apt. / POSTAL CODE / TELEPHONE

3 E-MAIL: / CELL

SEND **CHEQUE** TO: ☐ ADDRESS 1 ☐ ADDRESS 2 — SEND **CORRESPONDENCE** TO: ☐ ADDRESS 1 ☐ ADDRESS 2

STAY OUTSIDE MANITOBA

Trip during which you received healthcare services.

Date of departure (Year / Month / Day)

Date of return to Manitoba — Actual (Year / Month / Day) / Planned (if different) (Year / Month / Day)

Reason for trip (check one box only)

- ☐ Vacation or seasonal absence
- ☐ Work — Employer's name:
- ☐ School — Include a written certificate from the institution indicating the start and end dates of your courses.
- ☐ Receive medical care — If you requested authorization from Manitoba Health, indicate the authorization number:
- ☐ Other — Specify:

REIMBURSEMENT

Amount claimed:

Currency:

- ☐ Canadian dollars
- ☐ Other currency (specify): _____

Were bills paid?

- ☐ No
- ☐ Yes

If yes, please specify:

- ☐ Totally
- ☐ Partially: _____ (Paid amount)

HEALTHCARE SERVICES OUTSIDE MANITOBA

Indicate why you received healthcare services.

In the case of an accident, specify the type of accident:

☐ Motor vehicle accident ☐ Work related ☐ Other (specify):

Date of the accident (Year / Month / Day)

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: (Year / Month / Day)

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: _____ (Name of the insurance compagny) Policy No: _____ Certificate No: _____

Bank credit card: _____ (Name of the financial institution) Card No: ☐☐☐☐ ☐☐☐☐ XXXXX ☐☐☐☐

Other travel insurance:

PLEASE COMPLETE AND SIGN THE FRONT OF THIS FORM

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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: **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

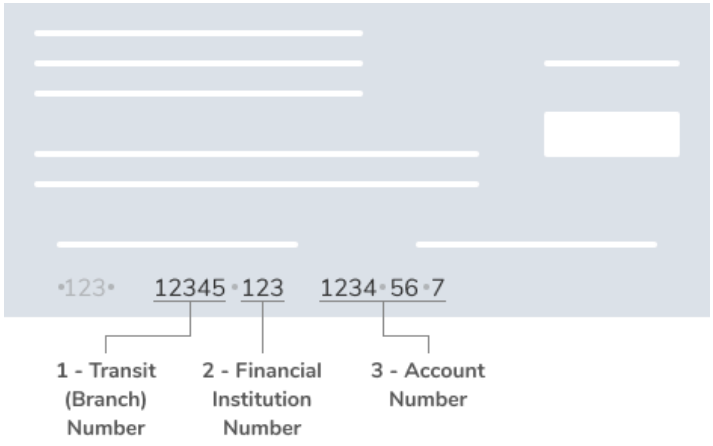
Name of the policyholder	Contract, certificate or identification number	File number

Bank Account Details (Canadian financial institutions only)

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