

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.

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

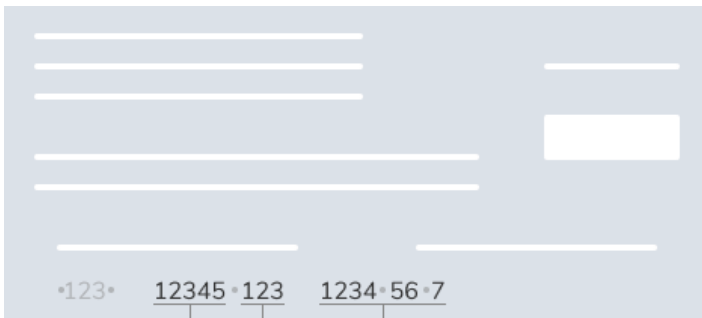
File number

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 _____

•123• 12345 •123 1234 •56•7
 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 _____

OUT-OF-PROVINCE CLAIM

SECTION A PATIENT INFORMATION (To Be Completed By Patient or Parent/Guardian) – PLEASE PRINT CLEARLY					
Patient Surname		All Given Names		MCP Number	
Surname at Birth (if different from above)		Date of Birth YYYY MM DD	Sex <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Return Home YYYY MM DD
Reason for Absence From Home: <input type="checkbox"/> Vacation <input type="checkbox"/> Business <input type="checkbox"/> Study – Name of Institution _____ <input type="checkbox"/> 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: <input type="checkbox"/> Treating physician <input type="checkbox"/> Patient / contract holder <input type="checkbox"/> 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 <input type="checkbox"/> Certified <input type="checkbox"/> Non-Certified	
Street / P.O. Box		City / Town	Province / State	Postal / Zip Code	
Name of Referring Physician		Services Provided In: <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Hospital In-Patient <input type="checkbox"/> Hospital Out-Patient			
If <input type="checkbox"/> Anesthetist <input type="checkbox"/> Surgical Assist <input type="checkbox"/> 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 YYYY MM DD	Duration
				YYYY MM DD	
				YYYY MM DD	
				YYYY MM DD	
				YYYY MM DD	
Diagnosis and Other Remarks					
Claim Involves: <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Pensionable Disability <input type="checkbox"/> Automobile Accident <input type="checkbox"/> Other Third Party		Physician's Signature		Date	Language of Correspondence <input type="checkbox"/> English <input type="checkbox"/> 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.