can assistance

TRAVEL INSURANCE CLAIM FORM

CONTRACT NO.

PATIENT INFORMATION (please complete 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 (DAY / MONTH / YEAR) — DATE OF RETURN: (REAL OR PLANNED) (DAY / MONTH / YEAR)

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 (DAY / MONTH / YEAR) — 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):

DO YOU HAVE OTHER INSURANCE COVERING THESE COSTS? ☐ YES ☐ NO

IF YES: INSURER'S NAME: POLICY NO. :

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

MEDICAL INFORMATION BEFORE DEPARTURE

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

NAME ADDRESS

NATURE OF ILLNESS : DATE OF LAST VISIT : (DAY / MONTH / YEAR)

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 (DAY / MONTH / YEAR) FILE NUMBER:

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

PATIENT'S AUTHORIZATION

1. I AUTHORIZE CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND 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 PURSUANT TO AND DURING THE PERIOD OF MY TRAVEL INSURANCE COVERAGE, INCLUDING ANY AUTHORIZED EXTENSION OF SUCH COVERAGE.
2. I IRREVOCABLY DIRECT AND AUTHORIZE MY PROVINCIAL HEALTH INSURANCE PLAN TO MAKE PAYMENT IN RESPECT OF MY CLAIM FOR HEALTH SERVICES INCURRED DURING SUCH TRIP TO CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND CANASSISTANCE INC. DIRECTLY AND I HEREBY RELEASE MY PROVINCIAL HEALTH INSURANCE PLAN, UPON PAYMENT TO CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND CANASSISTANCE INC. FROM ANY FURTHER CLAIM OR CAUSE OF ACTION IN CONNECTION THEREWITH AND I FURTHER INDEMNIFY MY PROVINCIAL HEALTH INSURANCE PLAN IN RESPECT OF SUCH PAYMENTS TO CANASSURANCE HOSPITAL SERVICE ASSOCIATION.
3. I HEREBY CONSENT AND AUTHORIZE MY PROVINCIAL 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 HEALTH INSURANCE PLAN TO CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND 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 CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL, PROVIDER, INSURANCE COMPANY OR PRE-PAYMENT ORGANIZATION WHO HAS ATTENDED OR EXAMINED ME OR MY FAMILY MEMBERS TO FURNISH TO CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND CANASSISTANCE INC. OR FOR THE PURPOSES OF COORDINATION OF BENEFITS ANY AND ALL INFORMATION REQUIRED IN CONNECTION WITH THIS CLAIM, INCLUDING INFORMATION WITH RESPECT TO SICKNESS, INJURY, MEDICAL HISTORY, CONSULTATIONS, MEDICINES, OR TREATMENT AND COPIES OF ALL HOSPITAL RECORDS FOR ME OR MY FAMILY MEMBERS.

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

SIGNATURE OF PATIENT OR PATIENT'S PARENT, GUARDIAN OR AUTHORIZED ATTORNEY — PRINT NAME — DATE

CONTRACTHOLDER (IF DIFFERENT FROM THE PATIENT)

LAST NAME	FIRST NAME	AGE

PROVINCIAL HEALTH NUMBER: TELEPHONE: HOME ( ) WORK ( )

ATTENTION: READ CAREFULLY

PLEASE SIGN THE CLAIM FORM. KEEP A COPY OF ALL THE DOCUMENTS, INCLUDE THE ORIGINAL COPY OF ALL YOUR RECEIPTS AND SEND IT ONLINE VIA OUR SECURE WEBSITE **CANASSISTANCE.COM/EN/POLICYHOLDER/DEPOT**

NOTICE: FAILURE TO INDICATE YOUR PROVINCIAL HEALTH INSURANCE NUMBER SHALL RESULT IN THE COMPENSATION BEING REFUSED.

OR BY MAIL TO THE FOLLOWING ADDRESS:
CANASSISTANCE
TRAVEL CLAIMS DEPARTMENT
1981, MCGILL COLLEGE AVENUE, SUITE 400
MONTREAL (QUEBEC) H3A 2W9

can assistance

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 the direct deposit option, please complete this form and attach a sample 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.

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** **1981, McGill College Avenue, Suite 400, Montreal, Quebec H3A 2W9**

Policyholder identification

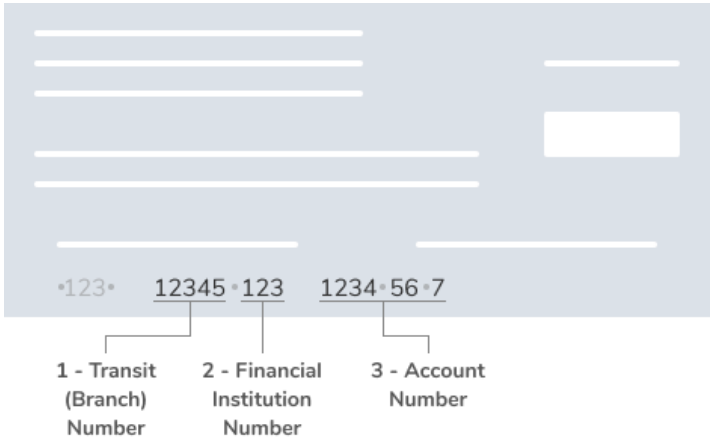
Name of the policyholder	Contract or certificate number	File number

Bank Account Details (Canadian financial institutions only)

To avoid payment errors and delays, please attach a sample 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 sample check, 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) into the aforementioned account number.

Signature of the policyholder _____ Date day / month / year _____