TRAVEL HEALTH MRM
TRAVEL MEDICAL INSURANCE CLAIM FORM

1 TRAVEL HEALTH MRM POLICYHOLDER INFORMATION

Name:_____
Address:_____
_____
_____

DATE: _____

HOME PH: (___)_____

WORK PH: _____

E-MAIL: _____

2 CLAIM INSTRUCTIONS

1. VERIFY THAT THE ABOVE INFORMATION IS ACCURATE AND MAKE CHANGES WHERE REQUIRED.
2. COMPLETE THIS FORM IN FULL AND ATTACH ALL DOCUMENTS AS REQUESTED.
3. SIGN AND DATE COMPLETED FORM AND RETURN PACKAGE TO:

TRAVEL HEALTH MRM
400 UNIVERSITY AVENUE, 15TH FLOOR
TORONTO, ON
M5G 1S7
CANADA
FOR CLAIMS INQUIRIES PLEASE CONTACT:
+1 (416) 642-2908 OR +1 (866) 222-0079.

FAILURE TO COMPLETE THE CLAIM FORM AND ATTACH REQUESTED DOCUMENTS WILL DELAY THE PROCESSING OF YOUR CLAIM.

PLEASE ATTACH THE FOLLOWING DOCUMENTS:

- ☐ ALL ORIGINAL MEDICAL BILLS AND PRESCRIPTION RECEIPTS
- ☐ A PHOTOCOPY OF THE SICK/INJURED PERSON'S PROVINCIAL HEALTH CARD
- ☐ IF INSURED UNDER MEDICAL SERVICES PLAN OF BRITISH COLUMBIA PLEASE COMPLETE THE ADDITIONAL FORMS ENCLOSED.
- ☐ DOCUMENTATION CONFIRMING YOUR DEPARTURE AND RETURN DATES (I.E. AIRLINE TICKETS, GAS RECEIPTS, ETC.)
- ☐ IN THE EVENT THAT YOU HAVE PAID ANY ELIGIBLE EXPENSES, PLEASE PROVIDE PROOF OF PAYMENT (I.E. CREDIT CARD VOUCHERS, CANCELLED CHEQUES, ETC.)

PLEASE KEEP A COPY OF ALL THE SUBMITTED CORRESPONDENCE FOR YOUR RECORDS.

WHAT TO EXPECT DURING THE CLAIMS PROCESS

IF YOU HAVE CONTACTED THE EMERGENCY ASSISTANCE CENTRE, WE WILL HAVE ARRANGED TO HAVE ALL BILLS SENT DIRECTLY TO TRAVEL HEALTH MRM AND ONCE ELIGIBILITY AND PAYABILITY ARE DETERMINED, THE APPROVED PAYMENTS WILL BE SENT DIRECTLY TO THE FACILITIES AND/OR HEALTH PROVIDERS.
IT IS OUR GOAL TO PROCESS ELIGIBLE CLAIMS IN A PROMPT MANNER, HOWEVER PROCESSING MAY BE DELAYED FOR THE FOLLOWING REASONS:

ELAY IN RECEIPT OF MAIL FROM PROVIDERS

ELAY IN RECEIPT OF MEDICAL INFORMATION FROM YOUR TREATING OR FAMILY PHYSICIAN

JCOMPLETE CLAIM FORM AND/OR INSUFFICIENT SUPPORTING DOCUMENTATION

PLEASE NOTE: DUE TO VARIATIONS IN HEALTH BILLING SYSTEMS BETWEEN COUNTRIES, YOU MAY RECEIVE INVOICES OR REMINDER NOTICES DIRECTLY FROM THE HEALTH PROVIDER. SHOULD YOU RECEIVE ANY SUCH CORRESPONDENCE **OR IF YOU HAVE PAID INVOICES DIRECTLY**, PLEASE FORWARD THESE TO THE ADDRESS INDICATED ABOVE, REFERENCING THE CASE NUMBER SHOWN AT THE TOP OF THE CLAIM FORM.

WE REQUEST THAT YOU SHOULD NOT PAY ANY MEDICAL ACCOUNTS DIRECTLY TO THE PROVIDERS UNLESS YOU HAVE BEEN ADVISED TO DO SO BY TRAVEL HEALTH MRM.

SHOULD YOU RECEIVE ANY PHONE CALLS REGARDING YOUR INVOICES, PLEASE DIRECT THE CALLER TO +1 (416) 642-2908 AND WE WILL PROVIDE THE APPROPRIATE INFORMATION.

IN ORDER TO EXPEDITE YOUR CLAIM, PLEASE RETURN THE COMPLETED CLAIM FORM AND ALL SUPPORTING DOCUMENTS AS SOON AS POSSIBLE AND KEEP A COPY FOR YOUR RECORDS.

3 INSURED DETAILS

YOUR TRAVEL HEALTH MRM POLICY NUMBER

NAME OF ILL OR INJURED PERSON	RELATIONSHIP TO INSURED	DATE OF BIRTH (DD/MM/YYYY)

PROVINCIAL HEALTH PLAN NUMBER OF CLAIMANT

DEPARTURE DATE (DD/MM/YYYY)	RETURN DATE (DD/MM/YYYY)

COMPLETE REVERSE AND ATTACH ALL DOCUMENTS AS REQUESTED IN SECTION TWO

TRAVEL HEALTH MRM
TRAVEL MEDICAL INSURANCE CLAIM FORM

CHARTIS

Name:_____

4 CLAIM DETAILS

NATURE OF SICKNESS OR INJURY	COUNTRY WHERE INCIDENT OCCURRED	DATE OF INCIDENT (DD/MM/YYYY)

DESCRIBE HOW INCIDENT OCCURRED

HAVE YOU PAID ANY INVOICES? ☐ NO ☐ YES IF YES, PROVIDE AMOUNT PAID: $ CURRENCY

NAME, ADDRESS AND TELEPHONE NUMBER OF ALL PHYSICIANS AND SPECIALISTS THAT THE CLAIMANT HAS SEEN PRIOR TO THE DEPARTURE DATE.

NAME AND SPECIALTY	ADDRESS	TELEPHONE NUMBER
NAME AND SPECIALTY	ADDRESS	TELEPHONE NUMBER
NAME AND SPECIALTY	ADDRESS	TELEPHONE NUMBER

5 OTHER INSURANCE COVERAGE (IF THE INSURED IS A CHILD, THIS SECTION IS APPLICABLE TO THE PARENT OR LEGAL GUARDIAN)

THIS INSURANCE PAYS ELIGIBLE EXPENSES IN EXCESS OF THOSE COVERED BY ANY OTHER INSURANCE. THEREFORE, IF AT THE TIME OF LOSS, YOU HAVE SIMILAR COVERAGE WITH ANOTHER PROVIDER (I.E. CREDIT CARD, TRAVEL INSURER, EMPLOYMENT GROUP HEALTH PLAN, PRIVATE OR PROVINCIAL AUTO PLAN, ETC.), WE WILL COORDINATE BENEFITS IN ACCORDANCE WITH THE CANADIAN LIFE AND HEALTH INSURANCE ASSOCIATION GUIDELINES.

PLEASE PROVIDE DETAILS (ATTACH ADDITIONAL INFORMATION IF NECESSARY)

DO YOU AND/OR YOUR SPOUSE OR CHILD HAVE OTHER TRAVEL INSURANCE BENEFITS? (CHECK ALL THAT APPLY)

☐ EMPLOYER ☐ CREDIT CARD ☐ OTHER TRAVEL INSURANCE ☐ A RETIREE PLAN ☐ HOME, AUTO OR OTHER PLAN ☐ N/A

1. EMPLOYER, RETIREE OR OTHER GROUP PLAN:

NAME (INSURED, SPOUSE, CHILD): _____

INSURANCE COMPANY: _____ POLICY/PLAN #: _____ ID/CERTIFICATE #: _____

EMPLOYER GROUP: _____ EMPLOYER NAME: _____

EMPLOYER PHONE: _____

2. CREDIT/BANK CARD:

ISSUING BANK: _____ CARD NO: _____

3. INDIVIDUAL PLAN:

NAME (INSURED, SPOUSE, CHILD): _____

INSURANCE COMPANY: _____ POLICY/PLAN #: _____ ID/CERTIFICATE #: _____

4. HOME, AUTO, OTHER PLANS:

INSURANCE COMPANY: _____ POLICY/PLAN #: _____ ID/CERTIFICATE #: _____

INSURANCE COMPANY: _____ POLICY/PLAN #: _____ ID/CERTIFICATE #: _____

☐ I HEREBY WARRANT THAT I DO NOT HAVE ANY OTHER TRAVEL OR OUT-OF-PROVINCE MEDICAL INSURANCE COVERAGE. (CHECK IF APPLICABLE)

6 CERTIFICATION AND AUTHORISATION

SPECIAL GHIP DIRECTION **(IF THE CLAIMANT IS A CHILD, THIS SECTION APPLIES TO A PARENT)**

I DIRECT AND AUTHORISE MY GOVERNMENT HEALTH INSURANCE PLAN (GHIP) TO MAKE PAYMENT IN RESPECT OF MY CLAIM FOR OUT-OF-COUNTRY HEALTH SERVICES TO **WORLD TRAVEL PROTECTION CANADA INC. (WTP)** DIRECTLY, AND I RELEASE GHIP, UPON PAYMENT TO WTP, FROM ANY FURTHER CLAIM OR CAUSE OF ACTION IN CONNECTION HEREWITH. I CONSENT TO THE DISCLOSURE BY GHIP TO WTP OF SUCH PERSONAL INFORMATION AS MAY BE NECESSARILY REQUIRED FOR PROCESSING OF MY CLAIM, INCLUDING DETAILS OF ANY DUPLICATE PAYMENT PREVIOUSLY MADE DIRECTLY TO ME.

I CONSENT AND AUTHORISE GHIP TO DIRECTLY OR INDIRECTLY COLLECT INFORMATION CONTAINED IN THE CLAIM AND SOURCE DOCUMENTS PURSUANT TO SECTION 39(1) OF THE FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT, AND TO SECTION 4(2)(F) OF THE HEALTH INSURANCE ACT.

PERSONAL INFORMATION NOTICE

I UNDERSTAND THAT THE INFORMATION PROVIDED BY ME ON THIS CLAIM FORM AND OTHERWISE IN RESPECT OF MY CLAIM, IS REQUIRED BY AMERICAN HOME ASSURANCE COMPANY, ITS REINSURERS AND AUTHORISED ADMINISTRATORS (THE "INSURER") TO ASSESS MY ENTITLEMENT TO BENEFITS, INCLUDING BUT NOT LIMITED TO DETERMINING IF COVERAGE IS IN EFFECT, INVESTIGATING THE APPLICABILITY OF EXCLUSIONS AND CO-ORDINATING COVERAGE WITH OTHER INSURERS. FOR THESE PURPOSES, THE INSURER WILL ALSO CONSULT ITS EXISTING INSURANCE FILES ABOUT ME, COLLECT ADDITIONAL INFORMATION ABOUT AND FROM ME, AND WHERE REQUIRED, COLLECT INFORMATION FROM AND EXCHANGE INFORMATION WITH THIRD PARTIES.

CERTIFICATION

THE STATEMENTS I PROVIDE IN COMPLETING THIS CLAIM FORM AND OTHERWISE IN RESPECT OF MY CLAIMS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. IN THE EVENT OF A FALSE OR MISLEADING STATEMENT IN THE MAKING OF THIS CLAIM, COVERAGE CAN BE CANCELLED, PAYMENT OF BENEFITS DENIED AND PAST CLAIMS PAYMENTS RECOVERED. I AGREE TO REFUND TO THE INSURER, THE AMOUNT OF ANY PAYMENTS MADE IN THE EVENT THAT SUCH AMOUNTS SHOULD NOT HAVE BEEN PAID IN RESPECT OF MY CLAIM.

AUTHORISATION

I AUTHORISE, FOR A PERIOD OF NOT LESS THAN TWELVE AND NOT MORE THAN TWENTY-FOUR MONTHS FROM THE DATE HEREOF, ANY PHYSICIAN, PRACTITIONER, HEALTH CARE PROVIDER, HOSPITAL, HEALTH CARE INSTITUTION, MEDICAL ORGANISATION, CLINIC AND ANY OTHER MEDICAL OR MEDICALLY RELATED FACILITY, ANY INSURANCE COMPANY OR REINSURANCE COMPANY, WORKERS COMPENSATION BOARD OR SIMILAR PLAN OR ORGANISATION, BENEFIT PLAN ADMINISTRATOR, FEDERAL, TERRITORIAL, OR PROVINCIAL GOVERNMENT DEPARTMENT, OR ANY OTHER CORPORATION OR ORGANISATION, INSTITUTION OR ASSOCIATION (INCLUDING OBTAINING INFORMATION FROM THE GROUP POLICYHOLDER OR MY EMPLOYER) TO RELEASE AND EXCHANGE WITH AMERICAN HOME ASSURANCE COMPANY, OR REPRESENTATIVES THEREOF, ALL PERSONAL HEALTH INFORMATION AND BENEFIT PAYMENT INFORMATION ABOUT ME OR ANY OTHER INFORMATION OR RECORDS ABOUT ME IN ITS POSSESSION THAT IS REQUESTED WHILE ADMINISTERING MY CLAIM.

I AGREE THAT A REPRODUCTION OF THIS AUTHORISATION SHALL BE AS VALID AS THE ORIGINAL.

FOR COMPLETE COVERAGE INFORMATION, PLEASE REFER TO YOUR CERTIFICATE OF INSURANCE.
ASSISTANCE AND CLAIMS SERVICES ARE PROVIDED BY WTP ASSIST.
BENEFITS ARE UNDERWRITTEN BY CHARTIS COMMERCIAL INSURANCE COMPANY OF CANADA.