CLAIM FORM

GlobalExcel®

Policy No. _____

File No. _____

SECTION A CLAIMANT INFORMATION (Please print)

PATIENT'S INFORMATION			POLICYHOLDER'S INFORMATION		
Last	First	Initial	Last	First	Initial
❑ Male ❑ Female	Date of birth (M/D/Y) ____/____/____		Address (number & street)	Date of birth (M/D/Y) ____/____/____	
Relationship: ❑ Self ❑ Spouse ❑ Dependent ❑ Check if child is full-time student			City	Province	Postal code
Provincial health number			Home: ( ) _____ Work: ( ) _____		
Family physician & all other physicians consulted within the ninety days prior to the date of departure			Diagnosis of illness or injury (while out of country)		
Country where claim occured	Date of incident (M/D/Y) ____/____/____		Currency		
Trip date (M/D/Y) From: ____/____/____ To: ____/____/____	For trips exceeding 182 days, please provide proof of provincial health insurance extension.		**Please indicate on each bill whether you have paid it or not.**		

SECTION B OTHER INSURANCE INFORMATION

Claimant's (or parent's) occupation ❑ Full time employment ❑ Self employed ❑ Student ❑ Retired ❑ Other: _____

Name of your employer: _____

Address: No. _____ Street _____ Suite No. _____ City _____

Province _____ Postal code _____ Telephone __ ( ) _____

Name of spouse's employer: _____

Address: No. _____ Street _____ Suite No. _____ City _____

Province _____ Postal code _____ Telephone __ ( ) _____

Employee group benefits plan ❑ Yes ❑ No Group policy No. _____ Name of covered person _____

Identification no.: _____ Name of insurance company: _____ Date of birth of insured (M/D/Y): _____

Credit card coverage ❑ Yes ❑ No Credit card no.: ___|___|___|___ ___|___|___|___ ___|___|___|___ ___|___|___|___

Card type / Bank _____ Name of the cardholder _____

Any other coverage (i.e: union, pensioner, private or other policy purchased prior to your departure)

❑ Yes ❑ No Policy No. _____ Name and address of insurance company / broker: _____

Are you covered by US Medicare: ❑ Yes ❑ No Plan No.: _____ Type: ❑ A ❑ B ❑ Both

SECTION C AUTHORIZATION TO PHYSICIANS, HOSPITALS, AND OTHER MEDICAL PROVIDERS

1. I, the undersigned, hereby authorize any hospital, physician, or medical facility to send my medical information to Global Excel Management Inc. authorized representatives of the insurer. I further consent to the disclosure of this information by Global Excel Management Inc. to other sources as may be required to obtain benefits from other sources.
2. I, the undersigned, hereby assign to Global Excel Management Inc. any benefits obtainable from other sources for covered losses under this policy. I also direct these sources to forward payment to Global Excel Management Inc. with regard to these losses.
3. I warrant that neither I nor any Insured Person have any additional coverage through any other insurer (other than that listed above).
4. I understand that my insurance shall be void if, whether before or after the loss, any person has concealed or misrepresented any fact or circumstance concerning this claim.

Claimant's or authorized person's signature _____ **Date** _____

For information or help filing your claim, please call toll free 1-800-336-9224 or visit our Web site at www.globalexcel.ca

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

AGREEMENT AND AUTHORIZATION TO PROVIDE HEALTH INFORMATION

BETWEEN Patient's Full Name _____
("the Resident")

AND Global Excel Management Inc. ("GEM")

AND Her Majesty the Queen in the Right of the Province of Alberta as Represented by the Minister of Health ("the Minister")

WHERE AS the Resident is eligible for Health Services and as such may receive payment for Health Services from the Minister.

AND WHERE AS the Resident is under an obligation pursuant to an insurance policy contract with GEM to remit to GEM all such payments received for Health Services from the Minister.

AND WHERE AS the Resident may be indebted to the Minister for Health insurance premiums under the Health Insurance Premiums Act, R.S.A. 1980, c.H-5 (as amended).

IN CONSIDERATION of the undertakings provided herein, the parties agree:

1. Subject to clause 2, the Resident assigns to GEM all sums of money that shall be owing to the Resident by the Minister for the above noted contract. The Minister is authorized to pay all such sums directly to GEM, with payment of any such sum to be sufficient discharge to the Minister of and from any indebtedness in that amount to the Resident, his heirs, executors, or administrators.
2. Prior to any payment being made by the Minister to GEM, the Minister is authorized by the Resident to deduct from the sums payable to GEM, any amount for which the Resident is indebted to the Minister for arrears in health insurance premiums owing under the Health Insurance Premiums Act.
3. This Agreement is effective from _____ (Departure date) to _____ (Return date)

I further hereby consent to and authorize the Minister of Health and Alberta Blue Cross (Coverage for Seniors) to furnish to any representative of Global Excel Management Inc., such records and information as may be disclosed in accordance with the Alberta Health Care Insurance Act, regarding claims for Health Services incurred while I had insurance coverage on the dates above-listed regardless of elapsed time. I also authorize Alberta Blue Cross (Coverage for Seniors) to coordinate benefits with Global Excel Management Inc.

DATED this _____ day of _____ , 20 _____.

_____ **Alberta Personal Health Card Number**

_____ **SIGNATURE**

_____ Telephone Number

_____ Address

_____

Important: **Accurately completing all details will assist us in settling your claim promptly.** Please attach original bills or receipts when submitting your claim. We recommend you keep copies for your own records.

☎ For Claim inquiries call **1-800-336-9224** or **819-566-8698**

❖❖❖❖ **Please complete the other side of this form** ❖❖❖❖