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 1-877-336-9224 or visit our Web site at www.globalexcel.ca

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

SCHEDULE A — ASSIGMENT OF PAYMENT DUE TO INSURED PERSON OR BENEFICIARY UNDER THE MEDICARE PROTECTION ACT OR HOSPITAL INSURANCE ACT

BETWEEN _____ of the first part, hereinafter referred to as the **Assignor**

AND Global Excel Management Inc. of the second part, hereinafter referred to as the **Assignee**

AND Her Majesty the Queen in the Right Of the Province of British Columbia as Represented by the Minister of Health herein referred to as the **Minister**

WHEREAS the Assignor is a person eligible for insured services or benefits or both under the Province of British Columbia's Medicare Protection Act or Hospital Insurance Act or both, and as such may receive payment for the above services from the Minister.

WHEREAS the Assignor is under a covenant or obligation under a contract of insurance with the Assignee to remit to the Assignee all such payments received for medical services from the Minister.

NOW WITNESSETH THAT in consideration of the said obligation to the Assignee the Assignor hereby assigns unto the Assignee all sums of money that shall be owing to the Assignor by the Minister for the above noted contract. The Minister is hereby authorized to pay all such sums directly to the Assignee at the address aforesaid, or at any address the Assignee may from time to time designate, with payment of any such sum to be sufficient discharge to the Minister of and from any indebtedness in that amount to the Assignor, his heirs, executors, or administrators.

DATED this _____ day of _____ , 20 _____

SIGNATURE OF ASSIGNOR _____

Witness:

Assignment: Effective from (travel dates) (M/D/Y) ____ /____ /____ to (M/D/Y) ____ /____ /____

SIGNATURE OF WITNESS _____

OCCUPATION OF WITNESS _____

SCHEDULE B — AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

I, _____ (or I, _____ parent/guardian of minor) hereby consent to and authorize the Ministry of Health to furnish to any representative of Global Excel Management Inc. any and all records and information in the Ministry of Health's possession regarding claims for Medical Services incurred while I had insurance coverage from (M/D/Y) ____ /____ / ____ to (M/D/Y) ____ /____ /____ including medical history and physical condition both prior and subsequent to receipt of Medical Services, regardless of lapsed time and bearing in any way on the Services received during the above time period.

DATED this _____ day of _____ , 20 _____

Personal Health Number _____

SIGNATURE _____

Address _____

_____

Telephone _____