## **CLAIM FORM**



Policy No.		
File No.		

SECTION A CLAIMANT INFORMATION (Please print)						
PATIENT'S INFORMATION		POLICYHOLDER'S INFORMATION				
Last First	Initial	Last	First	Initial		
	D. Clink was a			D		
☐ Male ☐ Female	Date of birth (M/D/Y)/	Address (number & street)		Date of birth (M/D/Y)		
Relationship:	se Dependent	City	Province	Postal code		
lacksquare Check if child is fu	☐ Check if child is full-time student					
rovincial 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:/	at a manager of the solution of	days, please provide proof trance extension.	Please indicate on each by you have paid it or not.	ill whether		
CECTION 5						
SECTION B OTHER INSU						
Claimant's (or parent's) occupation	☐ Full time employment☐ Retired	Self employed Other:	Stu			
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 🖵	Employee group benefits plan 🔲 Yes 🔲 No Group policy No Name of covered person					
Identification no.: Nam	Identification no.: Name of insurance company: Date of birth of insured (M/D/Y):			D/Y):		
<b>Credit card coverage</b> $\square$ Yes $\square$ No Credit of	ard 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 B Both						
Are you covered by 05 Medicare: 1 fes 1 No Fran No.:						
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.  I warrant that neither I nor any Insured Person have any additional coverage through any other insurer (other than that listed above).  I understand that my insurance shall be void if, whether before or after the loss,						
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 this claim.						
Claimant's or authorized person's signature Date Date						

## SCHEDULE "A" AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

I, (or, I	parent/guardian of _	, a minor)
hereby consent to and authorize Manitoba Heal	th to furnish to any representative of	, claim and payment
information in Manitoba Health's possession in	respect of claims for Medical Services incurred	for which I had insurance coverage from
including phys	ician/hospital name, date of service, and ser	vices provided (in-patient, out-patient,
physiotherapy, visit, procedure, x-ray or laborat	cory services).	
ASSIGNMENT OF PAYMENT DUE TO	O REGISTRANT UNDER THE HEALTH	I SERVICES INSURANCE ACT
I, (or, I	parent/guardian of _	, a minor)
hereby direct Manitoba Health to forward paymer	nt to, for any clai	ms for benefits under the Health Services
Insurance Act submitted by	in respect for medical and hospital s	services provided outside Canada.
DATED this day of	, 20	
Manitoba Health Registration Number	SIGNATURE	
	Address	
 Personal Health Identification Number		