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

AUTHORIZATION AND RELEASE

I, _____ irrevocably direct and authorize OHIP to make payment in respect of my claim for out-of-country health services to Global Excel Management Inc. directly and hereby release OHIP, upon payment to Global Excel Management Inc. from any further claim or cause of action in connection therewith.

I hereby consent and authorize OHIP 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 Section 4(2)(f) of the Health Insurance Act.

I consent to the disclosure by OHIP to Global Excel Inc. of such personal information as may be necessarily required for the processing of my claim for out-of-country health services, including the details of any duplicate payment previously made directly to me.

_____ _____

SIGNATURE **DATE**

_____ _____

YOUR ONTARIO HEALTH INSURANCE NUMBER **YOUR VERSION CODE***

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

* Depending on the date your Ontario Health Card was issued or renewed, your **VERSION CODE** may be two letters, one letter, or you may not yet have a **VERSION CODE**.

☎ For claim inquiries, call **1-800-336-9224** or **(819) 566-8698.**

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