

CLAIM FORM



Policy No. _____

File No. _____

SECTION A CLAIMANT INFORMATION (Please print)			
PATIENT'S INFORMATION		POLICYHOLDER'S INFORMATION	
Last	First	Initial	
<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of birth (M/D/Y)	
Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Check if child is full-time student		Address (number & street)	Date of birth (M/D/Y)
Provincial health number		City	Province Postal code
Family physician & all other physicians consulted within the ninety days prior to the date of departure		Home: () Work: ()	
Country where claim occurred		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 <input type="checkbox"/> Full time employment <input type="checkbox"/> Self employed <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No Policy No. _____ Name and address of insurance company / broker: _____			
Are you covered by US Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No Plan No.: _____ Type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> 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.	these sources to forward payment to Global Excel Management Inc. with regard to these losses.
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	3. I warrant that neither I nor any Insured Person have any additional coverage through any other insurer (other than that listed above).
Claimant's or authorized person's signature _____	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. 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

AUTHORIZATION AND RELEASE INVOLVING A MINOR

I, _____, parent/guardian of _____
(Name of parent or guardian) (Name of minor)

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 Management 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 OF PARENT OR GUARDIAN

DATE

MINOR'S ONTARIO HEALTH INSURANCE NUMBER

MINOR'S VERSION CODE NUMBER*

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. ❖❖❖❖