CLAIM FORM

GlobalExcel®

Policy No. _____

File No. _____

IMPORTANT: Failure to sign both sides of this form will result in a delay of the processing of your claim.

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

SCHEDULE "A"

ASSIGMENT OF PAYMENT DUE TO BENEFICIARY UNDER THE SASKATCHEWAN MEDICAL CARE INSURANCE ACT OR THE SASKATCHEWAN HOSPITALIZATION ACT

BETWEEN _____ of the first part, (the **Assignor**)
(Claimant name)

AND Global Excel Management Inc. of the second part, (the **Assignee**)

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

WHERE AS the Assignor is a person eligible for medical services under Saskatchewan Medical Care Insurance Act or the Saskatchewan Hospitalizaton Act or both, and as such may receive payment for the above services from the Minister.

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

NOW WITNESS THAT in consideration of the said obligation to the Assignee the Assignor herey 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 aforsaid, or at any address the Assignee may from time to time designate, his heirs, executors, or administrators.

DATED this _____ day of _____ , 20_____.

_____
SIGNATURE OF ASSIGNOR

Witness:

_____
Signature

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

_____
Occupation

SCHEDULE "A"

AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

I, _____ hereby consent to and authorize the department of Health to furnish to any representative of Global Excel Management Inc., claim and paymnet information in the Department of Health,s possession in respect of claims for Medical Services incurred while I had insurance coverage from _____ / _____ / _____ to _____ / _____ / _____
M D Y M D Y

including payment and claim information for the period within 6 months prior to the date of servce of the aforementioned Medical Services including physician/hospital name, date of service, and service profided (in-patient, out-patient, visit, procedure, x-ray or laboratory service or other medical treatment).

DATED this _____ day of _____ , 20_____.

_____
Personal Health Number

_____
SIGNATURE

_____
Address

_____

_____
Telephone

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