GlobalExcel®

VISITORS TO CANADA EMERGENCY TRAVEL INSURANCE
CLAIM FORM

Incident File No.: _____

Policy/Validation No.: _____

SECTION A PATIENT INFORMATION

Last Name:	First Name:	Date of Birth	M D Y
Address:	Apt.:		
City:	Country:	Postal Code:	Home Phone ( )
Diagnosis:		Where were services rendered?	
Total amount claiming for?	Date of incident M D Y		
Family Physician in country of residence:	Name:		
Your Employer	Address:	Phone ( )	
	Name:		
	Address:	Phone ( )	
Name of Canadian contact:	Address:	Phone ( )	

Was your loss the result of an automobile accident? ☐ Yes **OR** ☐ No (Go to section B)

Information about the vehicle owner and vehicle in which you were an occupant	Name:	Phone ( )	
	Address:	Accident Date	M D Y
Accident Location:	License Plate No.:	Year / Make of Car:	Auto Insurance Policy No.:
Insurance Company:	Address:	Phone ( )	
Information about **other** vehicle(s) involved	Name:	Phone ( )	
	Address:		
Accident Location:	License Plate No.:	Year / Make of Car:	Auto Insurance Policy No.:
Insurance Company:	Address:	Phone ( )	

SECTION B INFORMATION RELATING TO YOUR VISIT TO CANADA

Your Passport No.:	Visa No.:	Visa-type and length:
Country of residence/origin:	Date of arrival to Canada M D Y	Scheduled return date M D Y
Airline:	Airline ticket no.:	Point of entry into Canada:

SECTION C OTHER INSURANCE

❶ Are you covered by U.S. Medicare? ☐ YES ☐ NO

❷ Do you have group (employee/retiree) benefits? ☐ YES ☐ NO

If YES, please continue, otherwise proceed to question 3.

Your Group Benefits are provided by (check all that apply): ☐ Your employer ☐ Your spouse's employer ☐ A retiree plan

Name of employee/retiree: _____ Name of employer/group: _____

Group no.: _____ ID no. and/or Cert no.: _____

Name of insurance company: _____

Does the policy have a lifetime maximum? ☐ YES ☐ NO If YES, indicate lifetime maximum $ _____

❸ Do you have benefits provided by (check all that apply): ☐ Health insurance ☐ Home insurance ☐ Auto insurance ☐ Other

Name of insurance company: Policy/ID no.:

❹ Do you have a credit card coverage (i.e. Gold or other)? ☐ YES ☐ NO

If YES: Card no. Bank Name:

AS INDICATED IN YOUR POLICY, YOUR TRAVEL INSURANCE PLAN PROVIDES COVERAGE IN EXCESS OF ANY OTHER APPLICABLE INSURANCE (INDIVIDUAL, GROUP OR GOVERNMENT). FOR GLOBAL EXCEL MANAGEMENT INC., TO SEEK REIMBURSEMENT FROM THESE SOURCES YOU MUST COMPLETE THE FOLLOWING SECTION D.

SECTION D AUTHORIZATION AND RELEASE

1. I assign to Global Excel Management Inc. any indemnity obtainable from other sources for covered losses under this policy. I also direct these sources to forward payment to Global Excel Management, Inc. for my claims submitted by Global Excel Management Inc. with regard to these losses and to exchange information that facilitates this process.
2. I 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.
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.

✍ **Signature** _____ **Date** _____