

**OUT-OF-COUNTRY BENEFITS  
CLAIM FORM**

Benefits for medical and travel expenses incurred outside of Canada are subject to the limitations and exceptions in your Emergency Travel Medical Benefit Rider.

Please fully complete both sides of this statement of claim, including any attached Government Assignment Forms. Your claims cannot be considered unless these forms are completed in full.

**POLICYOWNER INFORMATION**

Policyowner Name \_\_\_\_\_  
 Policyowner Address \_\_\_\_\_  
City Province Postal Code  
 Phone Number: Home \_\_\_\_\_ Work \_\_\_\_\_  
 Policy Number   /  /  /  /  /   -   /  /  /  /  /  

**PATIENT INFORMATION**

Name of Patient \_\_\_\_\_  
 Address (if not the same as above) \_\_\_\_\_  
City Province Postal Code  
 Relationship to policyowner \_\_\_\_\_  
 Date of birth   /  /    
DAY MONTH YEAR  
 Address \_\_\_\_\_  
City Province Postal Code  
 Provincial Health Insurance Number   /  /  /  /  /  /  /  /  /  

**STATEMENT OF OTHER INSURANCE**

If the patient is entitled to travel and/or medical insurance benefits under any other policy (this includes other group insurance coverage, individual travel plans, or credit card plans) please provide the following information:

Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Credit Card Name of Insurance Company _____ Policy or Plan No. _____ Identification No. _____ Have you submitted a claim or otherwise contacted the other Insurance Company about this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Credit Card Name of Insurance Company _____ Policy or Plan No. _____ Identification No. _____ Have you submitted a claim or otherwise contacted the other Insurance Company about this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**CLAIM INFORMATION**

Purpose for travelling:  Vacation  Business  Other (specify) \_\_\_\_\_  
 Country visited: \_\_\_\_\_  
 Date of departure from home province   /  /    
DAY MONTH YEAR / Date of return to home province   /  /    
DAY MONTH YEAR /  
 What is the date you were originally scheduled to return to your home province?   /  /    
DAY MONTH YEAR /  
 Total value of receipts \$ \_\_\_\_\_ Currency \_\_\_\_\_ Canadian equivalent (if known) \_\_\_\_\_  
 Is patient eligible for benefits under his/her provincial health plan?  Yes  No  
 If No, why? \_\_\_\_\_  
 Please provide a brief description of the details surrounding your claim. \_\_\_\_\_  
 \_\_\_\_\_  
 What was the date of the initial onset of illness and/or injury?   /  /    
DAY MONTH YEAR /

If the patient was under age 60 on the policy effective date or its renewal date, please answer the following:

In the entire 90-day period immediately before leaving his/her home province:

- Did the patient experience any new symptoms or an increase in the frequency or severity of symptoms?  Yes  No
- Did the patient require medical attention consultation, diagnosis, treatment or hospitalization?  Yes  No
- Did the patient receive or require oxygen treatment or a change in treatment or medication (including dosage or usage)?  Yes  No

If the patient was age 60 or over on the policy effective date or its renewal date, please answer the following:

In the entire 365-day period immediately before leaving his/her home province:

- Did the patient experience any new symptoms or an increase in the frequency or severity of symptoms?  Yes  No
- Did the patient require medical attention, consultation, diagnosis, treatment or hospitalization?  Yes  No
- Did the patient receive or require oxygen treatment or a change in treatment or medication (including dosage or usage)?  Yes  No

Is the patient taking or has the patient taken any prescribed medication for any circulatory or heart condition, including the following conditions:

- |  |  |                           |  |
|--|--|---------------------------|--|
| Coronary artery disease:                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Congestive heart failure: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart attack:  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Atrial fibrillation:      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina:  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Aneurysm:                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Peripheral vascular disease:                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke:                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Transient ischemic attack:                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |                           |  |
| Any other circulatory or heart condition (specify) _____ |  |                           |  |

**DECLARATION AND AUTHORIZATION**

I/We authorize any licensed physician, medical practitioner, hospital or clinic or other medical or medically related facility or insurance company, to provide to The Great-West Life Assurance Company or any third parties designated by them, any and all information regarding my or my dependant's health or medical history, or treatment, as well as copies of all hospital or medical records. A photographic copy shall be as valid as the original.

I/We authorize The Great-West Life Assurance Company and any companies or persons designated by them to release any information regarding me/us to any medical provider or third parties in or outside Canada. A copy of this original shall be as valid as the original.

I/We certify that the information given is true, correct and complete to the best of my knowledge.

I/We authorize The Great-West Life Assurance Company and its agents to coordinate the payment of benefits with any other insurance carriers which may also have a liability for this claim. I/We hereby irrevocably direct The Great-West Life Assurance Company to make payments, receive payments and negotiate settlements with other carriers on the patient's behalf.

Policyowner (print full name) \_\_\_\_\_

Patient (print full name) \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

Please forward this form and original receipts to:

The Great-West Life Assurance Company  
P.O. Box 6000, Individual Health Unit  
Winnipeg, Manitoba, Canada R3C 3A5  
1-866-430-2863

Personal information we collect from you is kept in strict confidence and will be used to assess your claim and to administer the benefit plan.