OUT-OF-COUNTRY BENEFITS CLAIM FORM

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

Please fully complete both sides of this statement of claim, including any attached Government Assignment Forms. Your claim 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 __/__/__/__/__/__/__/__/__/__/__/__/

I authorize Canada Life to make payment directly to the providers of service.

Employee's signature: _____

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 ☐ Group ☐ Individual ☐ Credit Card

Name of insurance company _____

Policy or plan number _____

Identification number _____

Have you submitted a claim or contacted the other insurance company about this claim? ☐ Yes ☐ No

Type of coverage ☐ Group ☐ Individual ☐ Credit Card

Name of insurance company _____

Policy or plan number _____

Identification number _____

Have you submitted a claim or contacted the other insurance company about this claim? ☐ Yes ☐ No

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 _____

Is patient eligible for benefits under his/her provincial health plan? ☐ Yes ☐ No

If No, please explain _____

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 six month 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-days immediately prior to 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

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 Canada 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 certify that the information given is true, correct and complete to the best of my knowledge.
- I/We further authorize The Canada Life Assurance Company to release and/or receive medical information from providers and other carriers to facilitate the payment and coordination of this claim
- I/We authorize The Canada 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 authorize The Canada 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 Canada 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 Canada Life Assurance Company
Individual Health Unit
PO Box 6000
Winnipeg MB R3C 3A5
1-866-430-2863

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

IMPORTANT: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors. All claims under this plan are submitted by the policyowner. We may exchange personal information about claims with the policyowner and/or a person acting on their behalf when necessary to confirm eligibility and to mutually manage the claims.

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