Medical claim checklist
for out-of-country/province Canadians

Allianz
Global Assistance

To start your claim, follow the steps outlined in the checklist below.

- ☐ To complete this form electronically, save it with your case number, if you have it, and name as the filename (e.g. 1234567-First Name Last Name.pdf).
- ☐ Complete this claims package in full – we want to confirm we have all the right information for you.
- ☐ Gather and scan:
  1. Doctor's records, documents and invoices from the medical facility.
  2. Receipts for out of pocket expenses, including proof of payment (i.e. credit card statement showing only last 4 digits and/or receipts matching your bills and expenses).
  3. Prescriptions (official receipts including medication name, dosage and cost – not the store purchase receipt).
- ☐ If you have already started your claim by contacting us, add your case number to this form and all of your documents, receipts, invoices, etc.
- ☐ If you need more space, use the additional information section at the bottom of this form.
- ☐ Send this claim form and supporting documentation to us at submit@allianz-assistance.ca.
- ☐ Keep everything! This includes all original receipts, records, invoices, itineraries, supporting documentation and your claim form for a period of 1 year from the date of this submission. We might need you to mail them to us for verification.
- ☐ If you prefer, you can send your documents by mail:

  Allianz Global Assistance
  P.O. Box 277
  Waterloo, Ontario, Canada N2J 4A4

Here's what you can expect

- If we're missing information, we'll contact you.
- Each claim is unique, and some may require records from the medical facilities where you were treated along with clinical notes from your family doctor and/or specialist at home. Obtaining these records may take time.
- Your doctor may charge for help to complete this claim form, and you'll have to pay for this.
- Once we've reviewed your claim, you'll receive your explanation of benefits in the mail.

Thank you and take care,
The Claims Team, Allianz Global Assistance

Medical claim form
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Case/Claim number _____ Certificate/Policy number _____

Tell us about yourself (all questions on this form relate to the patient, unless otherwise specified)

First name _____ Last name _____

Email _____ Date of birth (MM/DD/YY) _____

Phone number _____ Alternate phone number _____

Do you have active provincial health coverage* ☐ Yes ☐ No **If 'Yes'**, please provide:

Provincial health card number _____ **Version code** (for some Ontario residents) _____

Home address

Street _____

City _____ Province _____ Postal code _____

Mailing address (if different than home address)

Street _____

City _____ Province _____ Postal code _____

Policyholder (if different from above)

First name _____ Last name _____

Date of birth (MM/DD/YY) _____

Tell us about your medical history

We need to ask you a few medical questions in order to collect the information we need to quickly review your claim.

Who is your family doctor/practitioner? ☐ I do not have a family doctor/practitioner

First and last name _____ Date of last visit (MM/DD/YY) _____

Phone _____ Email _____

Address _____

If you saw any specialists before you left on your trip, add their information below.
*(For additional specialists, use the **Additional Information** section at the end of this form.)*

First and last name _____

Area of specialty _____

Address _____

Phone _____ Email _____

Date first seen (MM/DD/YY) _____ Reason for visit _____

Date last seen (MM/DD/YY) _____ Reason for visit _____

Case/Claim number

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Tell us about your medical history from **before you left** on your trip.

Medical condition	Medications	Pending medical tests, procedures or follow-ups and their dates

Tell us about your trip

When did you leave your home province? (MM/DD/YY) _____

When were you supposed to come home? (MM/DD/YY) _____

When did you actually come home? (MM/DD/YY) _____

Where did you travel to?

City _____ Country _____

Tell us who treated you during your trip

Who was the treating physician? _____

Where were you treated? (name and address of clinic or hospital)

_____

Did you see a specialist? ☐ Yes ☐ No **If 'Yes'**, please provide:

Specialist's first and last name _____

Area of specialty _____

Their phone number _____ Date the specialist first saw you (MM/DD/YY) _____

Email _____

If you got sick, tell us what happened

When did you first notice symptoms? (MM/DD/YY) _____

When did you first seek treatment? (MM/DD/YY) _____

Have you experienced this sickness or a similar problem before? ☐ Yes ☐ No **If 'Yes'**, when? (MM/DD/YY) _____

How were you feeling, what were your symptoms, and what was the diagnosis?

Case/Claim number

Certificate/Policy number

If you were injured, tell us what happened

When, where and how did the injury happen?

When? (MM/DD/YY) _____ Where? _____

How?

If your injury occurred on private property:

Property owner _____ Phone number of property owner

Email of property owner _____

Did you file a report with the property owner (homeowner, hotel, etc.) or city responsible? ☐ Yes ☐ No **If 'Yes'**, when? (MM/DD/YY) _____

Please provide a copy of the report with this form. If no copy of the report is available, what is the report number? _____

If your claim relates to a motor vehicle accident, please provide the following information:

Did you file a report? ☐ Yes ☐ No **If 'Yes'**, where? ☐ Police ☐ Rental agency ☐ Collision reporting centre

Vehicle I was in:

Make/model	Name of auto insurance company	Phone number of auto insurance company	Vehicle owner	Policy number	Claim number (if applicable)

☐ I was driving ☐ I was a passenger ☐ I was a pedestrian

Other vehicles involved:

Please complete this section if you **DO NOT** *have a police report or a collision center self-report to produce with this claim form.*

Make/model	Name of auto insurance company	Phone number of auto insurance company	Vehicle owner	Policy number	Claim number (if applicable)

Did you seek legal counsel for either your injury or motor vehicle accident? ☐ Yes ☐ No

If 'Yes', provide**:**

Name of legal counsel _____ Law firm _____

Email _____ Telephone number _____

Case/Claim number

Certificate/Policy number

Tell us what you're claiming for

If you have additional expenses, please use the extra page at the end of this form.

Expense type (for example: physician services, medications, meals, accommodation)	Date of service (MM/DD/YY)	Amount billed	Amount you paid	Currency

Tell us about any other insurance you may have

Do you have additional coverage with another insurer? ☐ Yes ☐ No **If 'Yes'**, we will contact them and co-ordinate insurance benefits on your behalf.
If you have any other insurance policies, please check below and fill in the supporting information:

☐ Group benefits: Name of company _____ Policy/certificate number _____

☐ Credit card: Name of card _____

Primary card holder _____ First 6 digits _____ Last 4 digits _____

☐ Other travel insurance policies:

Name of company _____ Policy number _____

Have you already contacted your other insurance about this claim? ☐ Yes ☐ No

If 'Yes', who? _____ When? (MM/DD/YY) _____

Give permission to Allianz to discuss your claim with someone other than you

I authorize Allianz to discuss the details of my claim with (First, Last name) _____.

Relationship to me _____ Phone _____

Email _____

Case/Claim number

Certificate/Policy number

My Consent and Authorization

Check off each section to confirm you agree, and type your name into the patient signature field below.

☐ I certify that the information provided is complete, accurate and to the best of my knowledge. I understand that any incomplete, misleading or false information may lead to my coverage being voided, the payment of my claim denied, and claim payments made in error recovered.

☐ Personal Information Authorization

I understand that the personal information provided with respect to this claim is required by the insurer, administrator, and agents ("we") for the purpose of assessing entitlements to benefits and administering this claim. We may disclose the information collected to third parties within and outside of Canada for the purpose of providing assistance with administering your claim. All personal information will be retained and stored within Canada.

I authorize and consent to the release, exchange, or disclosure of my personal or medical information[1] with any medical provider, healthcare facility, insurance company, and legal representative for the purpose of assessing, investigating, administering, processing or subrogating this claim.

☐ Government Health Insurance Plan (GHIP) Authorization

I authorize my Government Health Insurance Plan (GHIP) to make a direct payment in respect of my claim to Allianz Global Assistance. Upon payment, I hereby release GHIP from any claim or cause of action in connection with my claim.

I authorize GHIP to directly or indirectly collect and use my personal information related to payment of this claim pursuant to the Freedom of Information and Privacy Act, the Health Insurance Act and the Personal Health Information Protection Act.

In the event that Allianz Global Assistance denies my claim, I understand and acknowledge that it will be my responsibility and obligation to pursue recovery from GHIP for reimbursement of out-of-country or province medical expenses. I understand that there is a limitations period applicable to my claim with GHIP and it is my responsibility to pursue the reimbursement within the limitations period. I hereby release Allianz Global Assistance from any financial obligations that may result due to the denial of my claim.

☐ Payment Authorization

For payments made on my behalf, I authorize any benefits paid or payable by any other insurance carrier in respect to this claim, to be assigned in whole or in part to Allianz Global Assistance, or if directed by Allianz Global Assistance, to the insurance company issuing the policy for payment being made.

☐ I acknowledge and agree that entering my name in the signature line below constitutes my signature, acceptance, and agreement to all of the terms and conditions provided herein with the same binding effects whether signed manually or electronically. Delivery of this claim form bearing an electronic signature to Allianz Global Assistance by way of email in portable document format (PDF) shall have the same effect as if it were physically delivered.

Patient signature _____ Date (MM/DD/YY) _____

Print name _____

Signature of designated legal proxy * _____

Print name of designated legal proxy * _____

* ***For minors:*** *If the patient is a minor, their legal guardian must sign on their behalf.*

* ***For legal representatives:*** *If a legal representative signs this form (power of attorney, executor/executrix, etc.), the provincial health plan requires proof of "Legal Representative" status.*

[1] IMPORTANT: Personal information excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

A photocopy of this authorization shall be considered as effective and valid as the original for the duration of this claim, not to exceed two (2) years from the date signed.

Case/Claim number

Certificate/Policy number

Tell us what you're claiming for

Expense type (for example: physician services, medications, meals, accommodation)	Date of service (MM/DD/YY)	Amount billed	Amount you paid	Currency

Additional information