



A. Personal Information

First Name _____ Last Name _____ Date of Birth DD / MM / YYYY
Destination Address _____ City _____ Province _____ Postal Code _____
Destination Phone () _____ Home Phone () _____
Home Address _____ City _____ Province _____ Postal Code _____
GMS Policy # _____ Email _____

B. Claims Instructions

1. Complete this form and attach in full as requested.
2. Sign and date completed form and return package to:
Group Medical Services
400 University Avenue, 15th Floor
Toronto, ON M5G 1S7
CANADA
For claims inquiries, please contact:
Toll Free 1-800-459-6604 (within Canada and the USA) OR
Collect (416) 260-4970 (from all other locations)
Failure to complete the claim form and attach requested documents will delay the processing of your claim.
Please attach the following documents:
All original itemized medical bills and prescription receipts
A photocopy of the sick/injured person's provincial health card
Documentation confirming your departure and return dates (i.e. airline tickets, gas receipts, etc.)
In the event that you have paid any eligible medical expenses, please provide proof of payment (i.e. credit card vouchers, cancelled cheques, etc.)
Please keep a copy of all the submitted correspondence for your records.

C. What to Expect During the Claims Process

If you have contacted the emergency assistance centre, we will have arranged to have all bills sent directly to Group Medical Services and once eligibility and payability are determined, the approved payments will be sent directly to the facilities and/or health providers.

It is our goal to process eligible claims in a prompt manner, however, processing may be delayed for the following reasons:

- Delay in the receipt of mail from providers billing direct
• Delay in receipt of medical information from your treating or family physician
• Incomplete claim form and/or insufficient supporting documentation

Please note: Due to variations in health billing systems between countries, you may receive invoices or reminder notices directly from the health provider. Should you receive any such correspondence or if you have paid invoices directly, please forward these to the addresses indicated above.

We request that you should not pay any medical accounts directly to the providers unless you have been advised to do so by Group Medical Services.

Should you receive any phone calls regarding your invoices, please direct the caller to (416) 260-4970 and we will provide the appropriate information.

In order to expedite your claim, please return the completed claim form and all supporting documents as soon as possible and keep a copy for your records.

D. Insured Details

Name of Ill or Injured Person _____
Provincial Health Plan Number of Claimant _____
Departure Date DD / MM / YYYY Return Date DD / MM / YYYY * Please make sure to attach documents confirming these dates.

COMPLETE REVERSE AND ATTACH ALL DOCUMENTS AS REQUESTED IN SECTION TWO

For complete coverage information, please refer to your policy.

E. Claim Details

Nature of Sickness or Injury _____ Date of Incident DD / MM / YYYY

Describe How Incident Occurred _____

Have you paid any invoices? Yes No If yes, provide amount paid \$ _____ Currency _____

Name, Address, and Telephone Number of all physicians and specialists that the claimant has seen prior to the departure date.

Name & Specialty _____ Address _____ Tel. Number (_____)

Name & Specialty _____ Address _____ Tel. Number (_____)

Name & Specialty _____ Address _____ Tel. Number (_____)

Did the patient suffer symptoms, receive medical advice, treatment, investigation, and/or was medication prescribed or changed for this medical condition

90 180 365 Days immediately Before Departure? Yes No

If yes, please describe _____

F. Group Medical Services Policy Information

Which Group Medical Services policy do you have? (check all that apply) TravelStar® Daily Emergency Medical TravelStar® Multi-Trip Annual Medical

TravelWise Daily Emergency Medical Individual Health Annual Travel (BasicPlan, ExtendaPlan®, OmniPlan®) Immigrants & Visitors to Canada StudentPlan

Group Name of Group _____ Policy/ID # _____

G. Other Insurance Coverage (If the insured is a child, this section is applicable to the parent or legal guardian)

This insurance pays eligible expenses in excess of those covered by any other insurance. Therefore, if at the time of loss, you have similar coverage with another provider (e.g. credit card, travel insurer, employment group health plan, private or provincial auto plan, etc.), we will coordinate benefits in accordance with the Canadian Life and Health Insurance Assurance guidelines.

Do you and your spouse or child have other travel insurance benefits? Yes No * **Please provide details (attach additional information if necessary)**

Type of Plan _____ Policy/ID/Credit Card # _____

Name and Address of Bank/Credit Card or Insurance Company _____

I hereby warrant that I do not have any other travel or out-of-province medical insurance coverage (check if applicable).

H. Certification and Authorization

The insurer, its agents, administrators and/or their designated representative(s), World Travel Protection Inc., (collectively "Group Medical Services") are obliged to collect and retain certain personal and/or health information about you in connection with your insurance coverage. They use and disclose that information only for the purposes of administering your policy/policies of insurance, providing customer service, and assessing and paying claims.

- I/We authorize any licensed physician, medical practitioner, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, provincial health insurance plan, and employer(s) to provide Group Medical Services and their respective representatives employed to assist in the administration of this claim any information, including personal information, data, or records that are in their possession/knowledge, regarding my medical history and treatment.
- I/we direct and authorize my government health insurance plan (GHIP) to make payment in respect of my claim for out-of-country health services to Group Medical Services, directly and I hereby release GHIP, upon payment to Group Medical Services, from any further claim or cause of action in connection herewith.
- I hereby consent and authorize GHIP to directly or indirectly collect information contained in the claim and source documents pursuant to the Freedom of Information and Protection of Privacy Act and the Health Information Protection Act.
- I/We Authorize Group Medical Services to coordinate the payment of benefits with any other insurance carriers which may also have a liability for this claim.
- I/We hereby authorize irrevocably Group Medical Services to make any payments, receive payments, and settle with any carriers on my behalf.

I hereby consent to the collection, use, and disclosure by the insurer, its agents, and administrators of the personal and health information about me disclosed herein and in all documents or information provided in connection with my policy/policies of insurance for the purposes cited above.

If the undersigned is signing on behalf of any person(s), the undersigned represents to having the authority to sign on behalf of such person(s) and confirms that each of the above declaration and authorizations are also provided on behalf of such person(s) and confirms that each of the above declaration and authorizations are also provided on behalf of such person(s).

A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from date signed.

Signature of Claimant **X** _____ Claimant _____ (Print Full Name) _____ Date DD / MM / YYYY

If claimant is dependant, print full name of parent or guardian, or if claimant is deceased, print full name of executor.