GLOBAL EXPATRIATE HOSPITAL & MEDICAL INSURANCE CLAIM FORM

TIC Claims Department
1200 – 438 University Avenue
Toronto, ON, Canada M5G 2K8
Collect worldwide: 416-340-8809
Toll free Canada/U.S.A.: 1-800-869-6747

INSTRUCTIONS

IMPORTANT

- In the event of a sickness or injury, TIC Travel Insurance Coordinators Ltd. (TIC) must be notified prior to, any medical consultation or any surgery being performed or within 24 hours of admission to hospital.
- All claims must be reported within 30 days of occurrence.
- Written proof of claim must be submitted within 60 days of occurrence.
- You are responsible for any fees charged for completing this form or issuing supporting documentation.

REQUIREMENTS

- Completed and signed claim form with all original bills and receipts. Photocopies will not be accepted.
- Medical Certificate for Global Expatriate Hospital & Medical Insurance, completed by the treating physician.
- Claim form must be completed by a parent or legal guardian if the insured is a minor.
- All bills must be itemized and show dates and costs of all treatment received.
- Please refer to the claims procedures in the policy booklet or your agent for details on what is required to substantiate your claim.

SECTION A: CLAIMANT INFORMATION

Insured's First Name: Last Name:

❑ Male ❑ Female Date of Birth: MM / DD / YYYY

Policy #: Telephone: ( ) Fax: ( )

Email:

Current Address:

City: Province: Postal Code:

Destination:

Departure Date: MM / DD / YYYY Return Date: MM / DD / YYYY

SECTION B: MEDICAL INFORMATION

In the case of an **injury**, how, when and where did it happen?

Please provide the following information if your claim relates to a motor vehicle accident.

Name of auto insurance company:

Address:

City: Province: Postal Code:

Telephone: ( ) Policy number with auto insurance company:

If your claim is due to **sickness**, when did you first notice symptoms? MM / DD / YYYY Date of first treatment: MM / DD / YYYY

What is the diagnosis?

Have you experienced this sickness or a similar problem before? ❑ Yes ❑ No If 'Yes', when? MM / DD / YYYY

Please provide attending doctor's name and telephone #:

Please provide the names of any medications you were taking prior to visiting the doctor:

Do you have any chronic sickness or disease? ❑ Yes ❑ No If 'Yes', please provide date diagnosed and describe condition/diagnosis:

Date diagnosed: MM / DD / YYYY Description:

Please provide the name of your usual family physician:

Address:

City: Province: Postal Code:

Telephone: ( ) Fax: ( )

Was the condition related to pregnancy? ❑ Yes ❑ No If 'Yes', please provide specific details:

Date of last menstrual period: MM / DD / YYYY Expected delivery date: MM / DD / YYYY

Was the condition related to the use of alcohol, misuse of drugs, or self-inflicted injury? ❑ Yes ❑ No

If 'Yes', please provide details:

SECTION C: EXPENSES CLAIMED

Amounts paid by you will be reimbursed to you if claim is eligible. Otherwise amounts will be paid directly to the provider of service.
You are financially responsible for the expenses not covered by your insurance.

Name of Service Providers (for example, doctors, hospitals, clinic)	Date of Service (MM/DD/YYYY)	Amount Billed	Amount You Paid
1.	MM/DD/YYYY		
2.	MM/DD/YYYY		
3.	MM/DD/YYYY		
4.	MM/DD/YYYY		
5.	MM/DD/YYYY		

SECTION D: OTHER INSURANCE COVERAGE – including Canadian government health insurance plan

(If the insured is a minor, this section is applicable to a parent or legal guardian.)

Do you have any other travel or out-of-country medical insurance coverage through your employer, your spouse's employer or a retiree plan?
❑ Yes ❑ No If 'Yes', provide details below.

Plan	Name of Insurance Company	Group Policy #	Member ID#	Telephone
Your Employer				( )
Your Spouse's Employer				( )
Retiree Plan				( )

Name of Spouse: Spouse's Date of Birth: MM/DD/YYYY

Do you have insurance benefits available through homeowner's insurance, automobile insurance, Canadian GHIP or any other source?
❑ Yes ❑ No If 'Yes', provide details below.

Plan	Name of Insurance Company	Policy #	Telephone
Homeowners Insurance			( )
Automobile Insurance			( )
Canadian government health insurance plan			( )
Other			( )

Do you have credit card insurance coverage for travel outside your province? ❑ Yes ❑ No

Name and address of issuing bank for credit card Name:

Street Address:

City: Province: Postal Code:

First 6 digits of credit card #: Expiry Date: MM/YY

Name of Cardholder (please print): Cardholder Signature:
(if different from insured)

Insured's Signature: Date: MM/DD/YYYY

SECTION E: AUTHORIZATION AND CERTIFICATION

TIC is committed to protecting the privacy, confidentiality and security of the personal information we collect, use and disclose. Your personal information will be used only for the purpose of providing you with the requested insurance services. For a copy of TIC's privacy policy, please contact us.

I authorize any doctor, hospital or facility providing medical or health-related services, and any other insurer to release and exchange with TIC or its representatives, any information that is required to process this claim. I assign to TIC any benefits payable from any other sources for losses covered under this policy, and I authorize and direct such payors to forward payment directly to TIC. I also authorize any third party providing me with assistance in this claims process, to have access to any and all relevant claims information related to the adjudication of my claim with TIC. I confirm I am authorized to act on behalf of my dependants for these purposes. A photocopy of this authorization shall be as valid as the original. I certify that the information provided in connection with this claim is complete, true and accurate.

Full Name of Patient/Insured (please print): Date: MM/DD/YYYY

I authorize payment of this claim to (print name):

Signature of Insured (if minor, signature of parent or legal guardian):

Signature of policyholder of other insurance in Section D (if applicable):