EMERGENCY MEDICAL EXPENSE CLAIM FORM

the co-operators® A Better Place For You®

Allianz Global Assistance

Please complete, sign and return promptly to Allianz Global Assistance. Without this information, we are unable to proceed with your claim.

P.O. Box 277
Waterloo, ON Canada
N2J 4A4

or

P.O. Box 71987
Richmond, VA USA
23255-1987

PATIENT INFORMATION

Patient Name:_____ Case:___-_____

Address:

City:_____ Province:_____ Postal Code:

E-mail: _____ Can we contact you via Phone / E-mail? (circle preference)

Patient's Date of Birth: _____ (MM/DD/YYYY) Gender: ☐ M ☐ F ☐ X Patient's Relationship to Policyholder: _____

Patient's Provincial Health Card Number: _____ version code (for some Ontario residents) _____

Policyholder Information (if different from patient)

Policyholder Name: _____ Policy No.: _____ Policyholder's Date of Birth: _____

Have you paid for treatment? ☐No ☐ Yes: Total amount being claimed: $_____

If "Yes", please specify service provider name, amount paid and currency of payment. If you have additional expenses please attach an additional page.

☐Partial or ☐Paid in Full (submit proof of payment) Service provider name:_____ Amount Pd:_____

☐Partial or ☐Paid in Full (submit proof of payment) Service provider name:_____ Amount Pd:_____

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TRAVEL DETAILS

Departure Date: _____ (MM/DD/YYYY) Anticipated/Scheduled Date of Return: _____ (MM/DD/YYYY) Actual Return Date: _____ (MM/DD/YYYY)

Nature of Travel: ☐Business ☐Vacation ☐Study ☐Medical Care ☐Other: _____ Destination: _____

Mode of Travel: ☐Car ☐Airplane ☐Other: _____ If applicable, was Extension of Coverage purchased? ☐No ☐Yes (specify)

OTHER INSURANCE INFORMATION FOR COORDINATION OF BENEFITS

Employer Information

If retired, specify name of employer providing benefits:

Employer Name: _____ Retired? ☐

Address: _____

Phone: _____

Spouse's Name:_____

Spouse's Date of Birth: _____ (MM/DD/YYYY)

Spouse's Employer: _____ Retired? ☐

Address: _____

Phone: _____

Please indicate all other insurance coverage you have through any other insurer: (i.e. employee/retiree/spousal group benefits, credit cards with insurance benefits, or any other purchased travel plan). Attach an additional page if required.

1) Name of Insurer: _____ Phone: _____

Address: _____ Lifetime payable limit on policy? ☐No ☐Yes (specify) $_____

Policy No: _____ Certificate No: _____ Signature of Policyholder: _____

2) Name of Insurer: _____ Phone: _____

Address: _____ Lifetime payable limit on policy? ☐No ☐Yes (specify) $_____

Policy No: _____ Certificate No: _____ Signature of Policyholder: _____

Credit Card Insurance coverage: include card type and bank: _____ Number:_____

Have you submitted these bills to any of the above insurance companies? ☐No ☐Yes If yes, which company?_____

SEE REVERSE FOR PAGE 2

MEDICAL INFORMATION

Please describe briefly, the situation leading you to seek medical attention, including the diagnosis.

_____

_____

Were medical services required as result of an accident? ☐Yes ☐No If "Yes", please provide details and include an accident report with this form.

_____

_____

Name of Hospital: _____ Date of Occurrence: _____
MM/DD/YYYY

Have you had any of these symptoms/conditions before? ☐Yes ☐No If "Yes", indicate the date you were **last** treated: _____
(including medications) MM/DD/YYYY

Please list all medications prescribed and taken **before** your departure date:

_____

When were your medications **last** changed **before** your departure (includes type and dosage): _____
MM/DD/YYYY

Name, Address and Phone No. of your Family Physician: _____

Name, Address and Phone No. of any Medical Specialist:_____

Date of your **last** medical visit (in Canada) before your trip? _____ Country where claim occurred: _____
MM/DD/YYYY

AUTHORIZATION

SPECIAL DIRECTION FOR GOVERNMENT HEALTH INSURANCE PLAN AND OTHER INSURANCE COVERAGE

I direct and authorize my provincial government health insurance plan (GHIP), including OHIP, to make a payment in respect of my claim for out-of-country health services to AZGA Service Canada Inc., doing business as Allianz Global Assistance, directly and I hereby release GHIP, upon payment to AZGA Service Canada Inc. from any further claim or cause of action in connection herewith.

I hereby consent and authorize GHIP, including OHIP, to directly or indirectly collect and use personal information including personal health information related to payment of my claim for out-of-country services (pursuant to Section 39 (1) of the Freedom of Information and Privacy Act, and for Ontario residents pursuant to the Health Insurance Act and the Personal Health Information Protection Act).

I consent to the disclosure by GHIP, including OHIP, to AZGA Service Canada Inc. of such personal information[1] including personal health information that is related to the processing and payment of my claim for out-of-country health services, including the details of any duplicate payment previously made directly to me. I understand that I may withhold my consent to the collection, use, disclosure of such information however, if I do so my claim cannot be processed and paid.

In consideration of payment 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 AZGA Service Canada Inc. or, if directed by AZGA Service Canada Inc., to the insurance company underwriting the policy for which such payment was made.

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that I have completed this claim form and that the answers given on Page 1 and Page 2 are complete, current and accurate to the best of my knowledge and belief.

I acknowledge that the submission of a false, incomplete or misleading information in the making of this claim, coverage can be void, payment of this claim denied and any claim payments made in error shall be recovered.

I authorize any physician, hospital or other medical provider who has attended or examined me to release to and exchange with Allianz Global Assistance or its representatives any and all information[1] regarding my medical history, symptoms, treatment, examination or diagnoses for the purpose of adjudicating my claim.

I authorize any other insurance carrier to release and exchange with Allianz Global Assistance or its representatives any medical or benefits payment information relating to this claim.

I understand that if I am a dependant under this insurance coverage, the named insured will have access to information related to this claim in connection with the administration of this plan.

I agree that a photocopy or facsimile of this authorization shall be valid as the original and that this authorization shall be considered valid for the duration of this claim, but not to exceed two years from the date it is signed. I understand information about me may be reviewed in the event that this plan is audited.

Name of Patient (Please print): _____ Date: _____
MM/DD/YYYY

Canadian Address: _____

Signature of **Patient / Designated Legal Proxy** *: _____ Phone No: _____

Signature of **Policy Holder**: _____ Date: _____
MM/DD/YYYY

[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.

* If the patient is a minor, his/her legal guardian must sign on his/her behalf. If a legal representative other than the patient's legal guardian signs this form, (power of attorney, executor/executrix etc.) the provincial health plan requires proof of "Legal Representative" status.

When sending original documents, be sure to keep a copy for your records.
If you have questions, please call us at 1-800-363-1835. Our Customer Service Team can help.