

VISITORS TO CANADA EMERGENCY MEDICAL EXPENSE CLAIM FORM

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

PATIENT INFORMATION

Patient Name: _____ Case: _____ - _____

Address where you are staying in Canada: _____

City: _____ Province: _____ Postal Code: _____

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

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

Policyholder Name: _____ Policy No.: _____ Policyholder's Date of Birth: _____
(MM/DD/YYYY)

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: _____

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Please indicate which address you wish payment to be made to: Address in Canada or Home Address (listed in the Authorization section below) if trip has ended at time of claim

*** Please note: All claim payments will be in Canadian Dollars. Claim payments that would violate any applicable national economic or trade sanctions law or regulations are prohibited.

TRAVEL DETAILS

Date Arrived in Canada: _____ Anticipated/Scheduled date of Departure from Canada : _____
(MM/DD/YYYY) (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

Please indicate all other insurance coverage you have through any other insurer which covers you while in Canada: (i.e. credit cards with insurance benefits, or any other purchased travel plan). Attach an additional page if required.

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 listed insurance company? 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 travel to Canada:

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 your Country of residence) before your trip? _____
(MM/DD/YYYY)

AUTHORIZATION

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 information¹ 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 information¹ 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)

Home Address: _____

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

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

* 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.) we require proof of "Legal Representative" status.

¹ **IMPORTANT:** All 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 sending original documents, be sure to keep a copy for your records.

If you have questions, please call us at 1-800-363-1835 (within North America), 011-1-519-742-2800 (from outside North America) or e-mail us at caclaimsInquiry@allianz-assistance.ca.