

# Medical claim checklist for non-Canadians

Allianz 

Global Assistance

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

To complete this form electronically, save and name it using your case number, if you have it, and full name. (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).
4. Proof of departure from your home country or arrival date in Canada.

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](mailto:submit@allianz-assistance.ca). Be sure to include your case number, if you have it, in the subject line.

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 are missing information, we will 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.
- Once we review your claim, you will receive your Explanation of Benefits in the mail.

Thank you and take care,

The Claims Team, Allianz Global Assistance

# Medical claim form for non-Canadians

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Case/Claim number \_\_\_\_\_

Certificate/Policy number \_\_\_\_\_

## Policyholder

First name \_\_\_\_\_ Last name \_\_\_\_\_

Date of birth (MM/DD/YY) \_\_\_\_\_

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

First name \_\_\_\_\_ Last name \_\_\_\_\_

Relationship to Policyholder \_\_\_\_\_ Date of birth (MM/DD/YY) \_\_\_\_\_

Email \_\_\_\_\_

Phone number \_\_\_\_\_ Alternate phone number \_\_\_\_\_

Your home country \_\_\_\_\_

Date you arrived in Canada (MM/DD/YY) \_\_\_\_\_ Date you left your home country (MM/DD/YY) \_\_\_\_\_

## Home address in country of origin

\_\_\_\_\_  
\_\_\_\_\_

## Mailing address in Canada

Street \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

## Tell us about your medical history **BEFORE** you arrived in Canada

*We need to ask you a few medical questions to collect the information we need to review your claim. For additional doctors / specialists, use the **Additional Information** section at the end of this form.*

### Who are your doctors / specialists in your home country?

First name \_\_\_\_\_ Last name \_\_\_\_\_

First and last name \_\_\_\_\_

Area of specialty \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Date of last visit (MM/DD/YY) \_\_\_\_\_ Reason for visit \_\_\_\_\_

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

Case/Claim number \_\_\_\_\_

Certificate/Policy number \_\_\_\_\_

## Tell us about your medical claim

Name of treating medical facility or physician \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

Number of visits \_\_\_\_\_ Date of last visit (MM/DD/YY) \_\_\_\_\_ Reason for visit \_\_\_\_\_

### 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?

Was your condition due to pregnancy? Yes No

**If 'Yes'**, when did you find out you were pregnant? (MM/DD/YY) \_\_\_\_\_ Expected date of delivery (MM/DD/YY) \_\_\_\_\_

### If you were injured (i.e. slip and fall, car accident), tell us what happened

When? (MM/DD/YY) \_\_\_\_\_ Where? \_\_\_\_\_

How?

### If your injury (i.e. slip and fall) occurred on private property (i.e. homeowner, hotel, etc.):

Property owner or location of incident \_\_\_\_\_ 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

Case/Claim number \_\_\_\_\_

Certificate/Policy number \_\_\_\_\_

**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 \_\_\_\_\_

**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 \_\_\_\_\_

Policy holder name \_\_\_\_\_ Date of birth (MM/DD/YY) \_\_\_\_\_

Credit card: Name of card \_\_\_\_\_

Primary card holder \_\_\_\_\_ First 6 digits \_\_\_\_\_ Last 4 digits \_\_\_\_\_

Card holder date of birth (MM/DD/YY) \_\_\_\_\_

Other travel insurance policies:

Name of company \_\_\_\_\_ Policy number \_\_\_\_\_

Policy holder name \_\_\_\_\_ Date of birth (MM/DD/YY) \_\_\_\_\_

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

**If 'Yes',** name of insurance company \_\_\_\_\_ When? (MM/DD/YY) \_\_\_\_\_

Have you applied for provincial health insurance in Canada?      Yes      No

**If 'Yes',** provide number: \_\_\_\_\_

Case/Claim number \_\_\_\_\_

Certificate/Policy number \_\_\_\_\_

## 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 and Last name) \_\_\_\_\_.

Relationship to me \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_

## My Consent and Authorization

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

By signing below, I am certifying that the information provided in connection with this claim is complete, true and accurate. I understand that any incomplete, misleading or false information may lead to: (1) my coverage being voided, (2) my claimed expenses being denied, (3) claim payments that were made in error being recovered from me or (4) any combination of (1)-(3) being taken by AZGA.

### 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. Transfer of information is in accordance with the [Allianz Binding Corporate Rules](#), which guarantee secure protection of personal data and are legally binding on all Allianz Group companies. All active personal information will be retained and stored within Canada for a period of seven (7) years.

I authorize and consent to the release, exchange, or disclosure of my personal or medical information<sup>1</sup> with any medical provider, healthcare facility, insurance company, reinsurer, government department and/or legal representative with Allianz Global Assistance, its underwriter, plan administrator, agent or representative for the purpose of assessing, investigating, administering, processing and/or subrogating this claim.

I understand I have the right to access, amend, delete and obtain a copy of personal information held by Allianz Global Assistance on my behalf. I further acknowledge I have the right to withdraw consent to the processing of my personal information as described within this authorization; however, any withdrawal of consent may prevent Allianz Global Assistance from being able to process my claim.

All individuals are entitled to contact the Allianz Global Assistance Privacy Officer for more information about our [Privacy Policy](#) or the processing of their personal information at: **Data Privacy Officer**, 4273 King Street East, Kitchener, Ontario N2P 2E9, [privacy@allianz-assistance.ca](mailto:privacy@allianz-assistance.ca).

### 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.

*If you wish to have benefits payable to you by Allianz Global Assistance made out to someone other than yourself, please complete the following authorization:*

I authorize payment of this claim to be made out to (please print):

First name \_\_\_\_\_ Last name \_\_\_\_\_

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.

<sup>1</sup> **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.

