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. 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

보험 청구를 시작할때 아래 상항을 참고 하세요.

1. 전자보험청구를 위해서, 보험 청구 양식을 내려받으시고, 파일 이름을 Case number(알리안츠 사를 통해 받은번호) 또는 약관 번호와 성함으로 파일을 만드시고 보험양식을 전자로 기입하세요. 서명란은 서명대신 이름을 기입하시면 됩니다.
2. 최대한 많은 정보를 기입하세요(보험사에서 의료 영수증만 보고 보험청구를 결정하기 쉽지 않습니다.)
3. 의료 영수증, 지불 영수증, 의료 처방서, 캐나다 입국날짜 증명 서류등을 스캔 또는 사진을 잘찍은후 PDF 파일로 저장해서 보험 청구서로 함께 "submit@allianz-assistance.ca" 로 이메일을 보내세요. PDF 가 아닌경우 파일을 열기 쉽지 않습니다.
4. 보내실때 hanmail 이나 Daum 메일은 수신,수령 불가하니 꼭 다른 이메일 주소를 사용하세요.
5. 최대한 간단히 무엇에 대한 보험청구인지를 설명하세요.
6. 만일 전자메일을 원하지 않으면, 청구서를 출력해서 위에 나와 있는 알리안츠 본사 주소로 일반 우편 으로 보내세요.

다음 페이지 샘플은 어깨 근육통 이유로 병원과 침술에 대한 보험청구 절차 입니다.

Medical claim form
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124563 보험사에 전화해서 받은 번호입니다.
Case/Claim number

1212112 보험 가입할때 받은 약관 번호입니다.)
Certificate/Policy number

Policyholder 만일 보험을 각각 가입했다면, Poliyholder 와 환자는 같은 사람입니다.

First name Gil Dong 주 가입자의 이름 입니다. Last name Hong 주 가입자의 성 입니다.

Date of birth (MM/DD/YY) 12/25/2002 주 보험가입자 생년월일입니다.

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

First name Gil Dong 환자의 이름 입니다. Last name Hong 환자의 성 입니다.

Relationship to Policyholder myself 환자와 주가입자의 관계입니다. Date of birth (MM/DD/YY) 12/22/2002

Email gildong@gmail.com hanmail.net 또는 Daum.net 은 보험사에서 보내는 이멜수신이 되지 않으니 다른 메일로 사용하세요.

Phone number 222-123-1245 전화번호 Alternate phone number 222-321-5421 다른 전화번호

Your home country South Korea 본국

Date you arrived in Canada (MM/DD/YY) 12/23/2019 도착날짜 Date you left your home country (MM/DD/YY) N/A 떠난날짜

아직 캐나다에 있다면, 안적으셔도 됩니다.

Home address in country of origin

N/A 만일 캐나다에 없다면, 본국 주소(청구수표를 받을 주소를 적으세요.)

N/A

Mailing address in Canada 만일 캐나다에 계신다면, 정확한 주소를 적으세요. 아파트 번호도 꼭 적으세요.

Street 123 Ottawa Street, Apt 123

City Ottawa Province ON Postal code X1X 2X2

Tell us about your medical history **BEFORE** you arrived in Canada 캐나다도착전 또는 기존 건강 질문

*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? 본국에 가정의가 있었다면, 의사 정보를 적으시고 없으면 빈공간으로 나두세요.

First name N/A Last name N/A

First and last name N/A

Area of specialty N/A

Address N/A

Phone Fax Email

Date of last visit (MM/DD/YY) N/A Reason for visit N/A

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

위에 정보는 보험청구와 관련없는 지병인 경우 적지 않으셔도 됩니다.

124563 보험사에 전화해서 받은 번호입니다.
Case/Claim number

1212112 보험 가입때 받은 약관 번호입니다.
Certificate/Policy number

Tell us about your medical claim 보험청구 관련 의료 정보 입니다.

Name of treating medical facility or physician: Dr. Smith John. Ottawa Medical clinic 진료의사 또는 담당의사 이름

Phone: 416-123-2525 전화번호 Email: Ottawamedical@gmail.com 의료 기관 이메일 주소

Address: 1 ottawa street, Ottawa, ON, Canada 의료 기관 주소

방문 횟수 Number of visits: 2 방문 날짜 Date of last visit (MM/DD/YY): 12/21/2019 Reason for visit: Pain in shoulder 의료기관 방문한 이유

If you got sick, tell us what happened

When did you first notice symptoms? (MM/DD/YY): 12/18/2019 의료 증상이 처음 생긴날짜

When did you first seek treatment? (MM/DD/YY): 12/19/2019 의료치료를 처음받은 날짜

Have you experienced this sickness or a similar problem before? ☐ Yes ☑ No **If 'Yes'**, when? (MM/DD/YY) _____
예전에도 같은 증상이 있었는지에 대한 질문 만일 있었다면, 증상이 생겼던 날짜

How were you feeling, what were your symptoms, and what was the diagnosis?

Feeling the pain on my right shoulder area, uncomfortable moving shoulder, The diagnosis was muscle stress and prescribed pain killer and recommend to receive Acupuncture treatment.

여기에는 간단히 증상, 증상 상태, 그리고 진료 결과 를 적으세요.

Was your condition due to pregnancy? ☐ Yes ☑ No 임신관련 증상인지 에대한 질문

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 사고로 인한 의료 증상인 경우 여기에 정보를 적으세요.

When? (MM/DD/YY) _____ 언제 Where? _____ 어디서

How? 어떻게

If your injury (i.e. slip and fall) occurred on private property (i.e. homeowner, hotel, etc.):의료 사고가 개인집, 호텔, 교회, 은행등 에서 생긴경우

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: 차사고로 인한 의료 증상인 경우 정보를 적으세요.
신고했나요?
Did you file a report? ☐ Yes ☐ No **If 'Yes'**, where? ☐ Police ☐ Rental agency ☐ Collision reporting centre

Vehicle I was in: 어떤 종류의 차를 타고 있었나요

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 운전였는지, 동행자 또는 행인

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Other vehicles involved: 다른 차와 접속 사고였나요? 경찰 또는 사고처리기관을 통해 리포트를 하지 않았다면, 여기에 정보를 자세히 적으세요.

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 이사고를 인해 변호사를 고용했나요?

If 'Yes', provide: 만일 변호사를 고용했다면, 변호사 정보를 기입하세요.

Name of legal counsel _____ Law firm _____

Email _____ Telephone number _____

Tell us what you're claiming for 보험청구하는 정보와 금액을 기입하세요.

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
Physician service	12/19/2019	$150	$150	Canada
Acupuncture service	12/22/2019	$150	$150	Canada

Tell us about any other insurance you may have 혹시 다른 유사한 보험에 청구할 예정이라면, 아래 타회사 보험정보를 기입하세요.

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: _____

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Case/Claim number	Certificate/Policy number

Give permission to Allianz to discuss your claim with someone other than you 제 3자가 보험청구를 도와 드리는경우

제 3자 이름 과 관계를 적으세요.

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[1] 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.

☑ **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:

보험청구 수표를 받을사람 이름을 적으세요. 보통 미성년자 부모님 이름

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

First name Saimdang Last name Shin

☑ 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 Hong, Gildong Date (MM/DD/YY) 12/25/2019

Print name Hong, Gildong

법정 대리인 서명 과 이름

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.*

[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.

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.

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Tell us what you're claiming for 위에 의료청구 관련 모자라는 부분을 여기에 적으세요.

Expense type (for example: physician services, medications, meals, accommodation)	Date of service (MM/DD/YY)	Amount billed	Amount you paid	Currency

Additional information