

# EMERGENCY MEDICAL EXPENSE CLAIM FORM



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: \_\_\_\_\_ Gender:  M  F  X Patient's Relationship to Policyholder: \_\_\_\_\_

MM/DD/YYYY  
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: \_\_\_\_\_

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

## TRAVEL DETAILS

Departure Date: \_\_\_\_\_ Anticipated/Scheduled Date of Return: \_\_\_\_\_ Actual Return Date: \_\_\_\_\_  
MM/DD/YYYY 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

**Employer Information** Spouse's Name: \_\_\_\_\_

**If retired, specify name of employer providing benefits:** Spouse's Date of Birth: \_\_\_\_\_  
MM/DD/YYYY

Employer Name: \_\_\_\_\_ Retired?  Spouse's Employer: \_\_\_\_\_ Retired?

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ 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? \_\_\_\_\_

## 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<sup>1</sup> 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<sup>1</sup> 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

<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.

\* 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.