Out-Of-Province/Country Hospital/Medical Insurance Claims Information Sheet

This document addresses frequently asked questions related to Out-Of-Province/Country Hospital/Medical Insurance claims

MEDICAL INJURY / SICKNESS CLAIMS

- The Out-Of-Province/Country Insurance Claim Form must be completed in full in order to process your claim. Please be sure to state **your departure** and **return** dates and **diagnosis**.
- In the event that the insured was initially seen in a hospital outside Canada, a copy of the *Hospital Discharge Report* must be submitted, if available.
- Please submit the following documents with the claim form:
  1. **Proof of travel:** copies of airline tickets, accommodation receipts, etc. showing your departure and return dates from/to province of residence.
  2. A copy of your **provincial health insurance card**.
  3. **Original itemized bills and receipts**. When submitting original documents, please be sure to keep a copy for your records.
  4. A copy of your **credit card statement** outlining the exchange rate, if expenses were paid for on your credit card.

IMPORTANT

- The Out-Of-Province/Country Insurance Claim Form must be filed with the Company within 90 days of the date of the injury/illness. Attach only original receipts for all expenses being claimed.
- Please note that it is the responsibility of the claimant to report their claim to us and to provide to us the supporting documentation outlined above.
- If you have more than one insurance carrier, benefits are coordinated.
- In the United States, it is customary for the provider of a particular service to send individual invoices. All such invoices should be forwarded to our office for our review.

WHAT TO EXPECT WHEN YOUR CLAIM IS RECEIVED...

- Please note that all claims are subject to standard adjudication processing. You should expect a response within 2-4 weeks. Our response would be one of the following:

(A) Payment or Notification of Payment to a Provider

(B) Request for more information if required

(C) Acceptance or Denial of the claim with reasons

Return completed claim form to:

INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC.
Life and Health Claims Department, Special Markets Solutions
400–988 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6
Tel: 1-800-549-7227
www.solutionsinsurance.com

In providing claim forms for the convenience of the claimant, the Company does not admit any liability or waive any of the terms and conditions of the policy. Provision of this claim form does not indicate coverage. Only eligible claims will be paid.

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Return to:
Life and Health Claims Dept.,
Special Markets Solutions
400–988 Broadway W, PO Box 5900
Vancouver, BC V6B 5H6

Out-Of-Province/Country Hospital/Medical Insurance Claim Form

Please print in ink

PATIENT INFORMATION

Member/Parent's Full Name

Policy Number

Patient/Dependent Full Name

Relationship to Member

Patient's Address :

Street

City

Province

Postal Code

Phone Number

Email Address

Patient's Health Card Number and Verification Code

Patient's Date of Birth (D D / M M M / Y Y Y Y)

If patient is a student, please provide name of School:

TRAVEL DETAILS

Departure Date (D D / M M M / Y Y Y Y)

Anticipated/Scheduled Date of Return (D D / M M M / Y Y Y Y)

Actual Return Date (D D / M M M / Y Y Y Y)

Nature of travel: ❑ Business ❑ Vacation ❑ Study ❑ Medical Care ❑ Other _____ Destination: _____

Mode of travel: ❑ Car ❑ Airplane ❑ Other _____

Were medical services required as the result of an accident? ❑ Yes ❑ No If "Yes", please provide details:

Whether sickness or accident please describe briefly the situation leading to you seeking medical attention, including the diagnosis.

Name of Hospital/Clinic/Dental Clinic _____ Date of Occurence (D D / M M M / Y Y Y Y)

Name of Physician/Dentist consulted

Street

City

Province

Postal Code

Did you call our assistance line within 24 hours? ❑ Yes ❑ No If yes, please provide your Case Number: _____

Have you had any of these conditions before? ❑ Yes ❑ No If "Yes", indicate the date you were **last** treated (D D / M M M / Y Y Y Y)

Please list all medication in use **before** your departure date: _____

Any medication change **before** your departure date? ❑ Yes ❑ No If "Yes", provide details on an additional page.

Name, address and phone # of your Family Physician in Canada: _____

Date of your **last** medical visit in Canada before your trip (D D / M M M / Y Y Y Y) Country where claim occurred _____

Have you paid for your treatment? ❑ Yes (❑ Full ❑ Partial) ❑ No If "Yes", please submit proof of payment.

Total amount being claimed: $_____ Currency: _____

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OTHER INSURANCE INFORMATION

Name of Employer

Name

Address: Street

City | Province | Postal Code | Phone Number

Name of Company who carries your Group Hospital/Medical Insurance or Extended Health Plan

Policy /Group No. | Identification/Certificate No.

Do you carry other Travel medical insurance? (This includes coverage offered through premium credit cards)

Yes ❑ No ❑

If Yes to above, please provide the Name of the Other Insurer:

If you have other travel medical insurance, have you contacted the other insurer regarding this medical emergency? ❑ Yes ❑ No

If Yes, please provide the date you first contacted the other insurer: (D D / M M M / Y Y Y Y)

Please provide your policy and claim number with the other travel insurer:

Policy #:_____ Claim Number #: _____

If injuries are the result of an automobile accident, advise name of Insurance Company

Policy Number | Claim Number | Name of Insured, if other than yourself

Address of Insured, if other than yourself: Street

City | Province | Postal Code | Phone Number

AUTHORIZATION AND DECLARATION

I hereby CERTIFY that the information contained in this Claim Form is true and complete to the best of my knowledge.

On behalf of myself and/or any minor insured, I RELEASE the information contained in this Claim Form to Industrial Alliance Insurance and Financial Services Inc. (the "Company") and ACKNOWLEDGE that this information will be used to assess, process and administer this claim and policy coverage. I AUTHORIZE any health care provider, insurance company, school or school board, employer, or other person or other organization to disclose to the Company any medical information, information regarding charges, or other information that the Company may need in their assessment of this claim.

I AUTHORIZE the Company to exchange the information detailed in this Claim Form and other information contained in files related to this claim or coverage with any of the parties identified in the previous paragraph for the purposes listed above, or as authorized by me, or as legally required.

Date Signed (D D / M M M / Y Y Y Y)

Signature of Insured Patient or Parent or Legal Guardian

Please attach original receipts for all eligible expenses being claimed. If available, please provide copies of any medical records you may have been provided with in connection with your diagnosis/treatment.