IMPORTANT NOTICE

A duly completed and signed claim form is necessary even if you have not made any payments. Your provincial health plan covers partially some of the fees for medical care received during your trip. CanAssistance reimburses these fees in full and will collect the amount payable on your behalf.

Filing a claim

Complete and sign the claim form

- Each person who received healthcare services must complete a claim form.
- Ensure you also complete and submit the provincial health plan form.

Attach the following documents:

- Original itemized bills for all healthcare services received, the diagnosis and treatment must appear clearly.
- Original prescription drug receipts showing the name of the drug, the dosage and the price.
- Proof of payment for all expenses claimed, such as a credit card statement or proof of a deposited cheque showing the currency in which the service was paid. In the absence of a bank or credit card statement, a receipt may be accepted.
- Proof of your departure and return dates, such as a plane ticket, a stamped copy of your passport, a bank or credit card statement showing purchases made in Canada just before your departure date and immediately after your return.
- Any other relevant document(s), such as medical reports, lab results, etc.

Send the duly completed forms and all other required scanned documents online via our secure website:

canassistance.com/en/policyholder/depot

We reserve the right to request the original documents up to one year from the date of submission of your claim.

Or send the forms and original claims documents by mail to:

CanAssistance
Travel Claims Departement
PO BOX 3888, Station B
Montreal, Quebec, H3B 3L7

Additional Information

You may make copies of all submitted documents for your files, as they will not be returned.

Your claim will be reviewed as quickly as possible once we have received the required documents. The following situations may increase the time it takes us to process your claim:

- An incomplete claim form or missing document
- Delayed or missing detailed invoice
- Delayed or missing medical information

Eligible expenses are reimbursed in Canadian funds by cheque made out to the Primary plan member. If you are covered by more than one travel insurance policy, indicate this on your claim form. We will work with the other issuer to coordinate your benefits as needed.

If you receive a bill, please do not make any payments directly to the service provider unless we instruct you to do so. Simply send it to the address above.

Should you have any questions about your claim, please contact our customer service toll-free at 1-855-445-5173 or 1-825-509-7675 Monday through Friday from 8:30 am to 8:00 pm (EST) or by email at bluecross@canassistance.com.

Disclaimer: Email is not a secure method of communication and should only be used for the transmission of non-confidential information.

can assistance

TRAVEL INSURANCE CLAIM FORM

CONTRACT NO.

PATIENT INFORMATION (please complete separate form for each person)

PROVINCIAL HEALTH NUMBER	LAST NAME	LAST NAME AT BIRTH (if different)
	FIRST NAME	DATE OF BIRTH (YEAR / MONTH / DAY) — SEX ☐ M ☐ F

PERMANENT ADDRESS IN CANADA

	POSTAL CODE	TELEPHONE NO.	HOME (AREA CODE)	WORK (AREA CODE)

STAY OUTSIDE CANADA/PROVINCE

DATE OF DEPARTURE (DAY / MONTH / YEAR) — DATE OF RETURN: (REAL OR PLANNED) (DAY / MONTH / YEAR)

REASON FOR TRIP

- ☐ VACATION
- ☐ WORK — NAME OF EMPLOYER:
- ☐ STUDIES — INCLUDE A WRITTEN CERTIFICATE FROM THE INSTITUTION:
- ☐ OTHER — DESCRIBE:

SERVICES AND CARE RECEIVED

INDICATE THE REASON WHY YOU RECEIVED MEDICAL OR HOSPITAL SERVICES:

DESCRIBE THE CARE RECEIVED (E.G.: EXAMINATION, X-RAYS, SURGERY, ETC. IF SPACE IS INSUFFICIENT, ATTACH ANOTHER SHEET.

CITY AND COUNTRY WHERE THE SERVICES WERE RECEIVED:

IN THE CASE OF AN ACCIDENT, INDICATE:

DATE OF THE ACCIDENT (DAY / MONTH / YEAR) — TYPE OF ACCIDENT: ☐ TRAFFIC ☐ WORK RELATED ☐ OTHER (SPECIFY):

HAVE THE BILLS BEEN PAID? ☐ YES ☐ NO **IF YES:** ☐ IN FULL ☐ PARTLY

AMOUNT PAID

CURRENCY ☐ CANADIAN DOLLARS ☐ OTHER (SPECIFY):

DO YOU HAVE OTHER INSURANCE COVERING THESE COSTS? ☐ YES ☐ NO

IF YES: INSURER'S NAME: POLICY NO. :

IF THAT COVERAGE IS FROM YOUR CREDIT CARD, PLEASE INDICATE YOUR CREDIT CARD NUMBER:

MEDICAL INFORMATION BEFORE DEPARTURE

DOCTOR AND SPECIALIST (IF NECESSARY) IN CANADA BEFORE DEPARTURE :

NAME ADDRESS

NATURE OF ILLNESS : DATE OF LAST VISIT : (DAY / MONTH / YEAR)

HAVE YOU BEEN HOSPITALIZED IN CANADA IN THE LAST 6 MONTHS PRIOR TO YOUR TRIP ? ☐ YES ☐ NO

NATURE OF ILLNESS

NAME OF HOSPITAL CITY

ADMISSION DATE (DAY / MONTH / YEAR) FILE NUMBER:

LIST THE MEDICATION(S) YOU WERE TAKING DURING THE 6-MONTH PERIOD PRECEDING YOUR DEPARTURE :

PATIENT'S AUTHORIZATION

1. I AUTHORIZE CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND CANASSISTANCE INC. AND ITS SIGNING OFFICERS AS MY ATTORNEYS TO RECEIVE IN MY NAME AND ENDORSE AND NEGOTIATE ON MY BEHALF, CHEQUES AND OTHER FORMS OF PAYMENT FROM MY PROVINCIAL OR TERRITORIAL HEALTH INSURANCE PLAN FOR THE REIMBURSEMENT OF CLAIMS RELATING TO HOSPITAL AND MEDICAL SERVICES INCURRED DURING A TRIP OUTSIDE MY PLACE OF RESIDENCE PURSUANT TO AND DURING THE PERIOD OF MY TRAVEL INSURANCE COVERAGE, INCLUDING ANY AUTHORIZED EXTENSION OF SUCH COVERAGE.
2. I IRREVOCABLY DIRECT AND AUTHORIZE MY PROVINCIAL HEALTH INSURANCE PLAN TO MAKE PAYMENT IN RESPECT OF MY CLAIM FOR HEALTH SERVICES INCURRED DURING SUCH TRIP TO CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND CANASSISTANCE INC. DIRECTLY AND I HEREBY RELEASE MY PROVINCIAL HEALTH INSURANCE PLAN, UPON PAYMENT TO CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND CANASSISTANCE INC. FROM ANY FURTHER CLAIM OR CAUSE OF ACTION IN CONNECTION THEREWITH AND I FURTHER INDEMNIFY MY PROVINCIAL HEALTH INSURANCE PLAN IN RESPECT OF SUCH PAYMENTS TO CANASSURANCE HOSPITAL SERVICE ASSOCIATION.
3. I HEREBY CONSENT AND AUTHORIZE MY PROVINCIAL HEALTH INSURANCE PLAN TO DIRECTLY OR INDIRECTLY COLLECT INFORMATION CONTAINED IN THE CLAIM AND SOURCE DOCUMENTS PURSUANT TO APPLICABLE PROVINCIAL LEGISLATION.
4. I CONSENT TO THE DISCLOSURE BY MY PROVINCIAL HEALTH INSURANCE PLAN TO CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND CANASSISTANCE INC. OF SUCH PERSONAL INFORMATION AS MAY BE NECESSARILY REQUIRED FOR THE PROCESSING OF MY CLAIM FOR SUCH HEALTH SERVICES, INCLUDING THE DETAILS OF ANY DUPLICATE PAYMENT PREVIOUSLY MADE DIRECTLY TO ME.
5. I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL, PROVIDER, INSURANCE COMPANY OR PRE-PAYMENT ORGANIZATION WHO HAS ATTENDED OR EXAMINED ME OR MY FAMILY MEMBERS TO FURNISH TO CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND CANASSISTANCE INC. OR FOR THE PURPOSES OF COORDINATION OF BENEFITS ANY AND ALL INFORMATION REQUIRED IN CONNECTION WITH THIS CLAIM, INCLUDING INFORMATION WITH RESPECT TO SICKNESS, INJURY, MEDICAL HISTORY, CONSULTATIONS, MEDICINES, OR TREATMENT AND COPIES OF ALL HOSPITAL RECORDS FOR ME OR MY FAMILY MEMBERS.

A PHOTOCOPY OF THIS AUTHORIZATION AS SIGNED BY ME, MY PARENT, GUARDIAN OR AUTHORIZED ATTORNEY SHALL BE AS VALID AS THE ORIGINAL.

SIGNATURE OF PATIENT OR PATIENT'S PARENT, GUARDIAN OR AUTHORIZED ATTORNEY	PRINT NAME	DATE

CONTRACTHOLDER (IF DIFFERENT FROM THE PATIENT)

LAST NAME	FIRST NAME	AGE

PROVINCIAL HEALTH NUMBER: TELEPHONE: HOME ( ) WORK ( )

ATTENTION: READ CAREFULLY

PLEASE SIGN THE CLAIM FORM. KEEP A COPY OF ALL THE DOCUMENTS, INCLUDE THE ORIGINAL COPY OF ALL YOUR RECEIPTS AND SEND IT ONLINE VIA OUR SECURE WEBSITE **CANASSISTANCE.COM/EN/POLICYHOLDER/DEPOT**

NOTICE: FAILURE TO INDICATE YOUR PROVINCIAL HEALTH INSURANCE NUMBER SHALL RESULT IN THE COMPENSATION BEING REFUSED.

OR BY MAIL TO THE FOLLOWING ADDRESS:
CANASSISTANCE
TRAVEL CLAIMS DEPARTMENT
PO BOX 3888, STATION B
MONTREAL (QUEBEC) H3B 3L7

can assistance

REQUEST FOR PAYMENT BY DIRECT DEPOSIT

IMPORTANT NOTICE

If your claim is deemed admissible, by default a cheque will be sent to the policyholder. If you prefer to receive the reimbursement in your chequing account through the direct deposit option, please complete this form and attach a sample cheque.

We recommend that you select direct deposit for a number of reasons:

- Avoid the many possible days that come with receiving cheques by mail.
- Access your funds immediately without any holds that may be required by your financial institution.

Online via our secure website: **canassistance.com/en/policyholder/depot** Send all scanned documents and keep originals. We reserve the right to request the original documents up to one year from the date of submission of your claim.	*By regular mail :* **CanAssistance, Travel Claims Department** **PO BOX 3888, Station B, Montreal, Quebec, H3B 3L7**

Policyholder identification

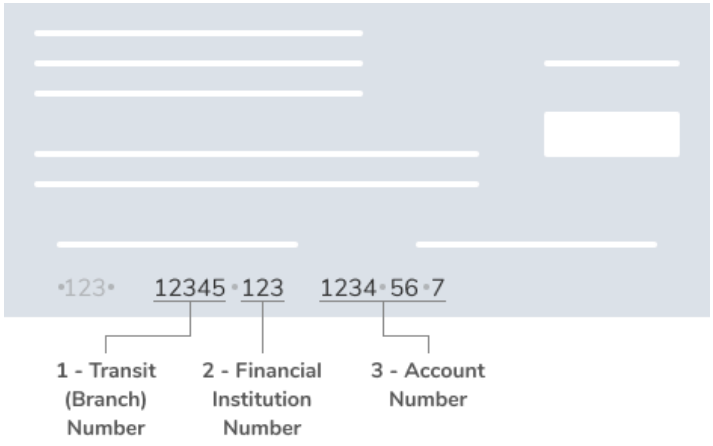
Name of the policyholder	Contract or certificate number	File number

Bank Account Details (Canadian financial institutions only)

To avoid payment errors and delays, please attach a sample cheque. A copy can also been obtained through the online banking services of your financial institution.

Scan the document or take a photo of it, making sure all information is legible.

If you are unable to provide a sample check, please carefully complete the sections below.



Branch number _____

Institution number _____

Account number _____

I hereby request that my benefits be paid via electronic funds transfer (direct deposit) into the aforementioned account number.

Signature of the policyholder _____ Date day / month / year _____

Alberta Government

Insurance Claim Consent and Authorization

Alberta Health
Out-of-Country Claims Unit
10025 Jasper Avenue NW
PO Box 1360 Station Main
Edmonton AB T5J 2N3

Key Information for Requesting Reimbursement for an Insurance Claim

- Personal information and health information that Alberta Health collects and discloses is used for the purposes of payment of benefits to Secondary Insurers, Brokers or Third Party.
- The enclosed Insurance Claim Consent and Authorization form will provide the authority for Alberta Health to assign payments to the secondary insurers, brokers or third party. This means the payment for hospital and physician services the patient receives will be made directly to the secondary insurers, brokers, or third party.
- ***Authorization for the release*** of health information and personal information is **only** valid for services provided during the period between the From and To dates on page two.
- The ***effective date*** section of this consent is time sensitive to allow for medical service claim(s) processing, and is revocable at any time by the Alberta resident with written notice to the Out-of-Country Claims Unit of Alberta Health.

Form Completion Instructions

All sections of the form on the next page must be completed in full and proof of payment provided. Omissions will result in an insurance claim not being processed.

Patient Information

- **Name of Patient** - print the full legal name of the patient who is receiving health services outside of Canada.
- **Alberta Personal Health Number** (PHN) - this is a unique 9-digit number assigned to all Albertans registered with the Alberta Health Care Insurance Plan that appears on the Alberta Health Care card.

Authorization for Release of Health Information

- **Information can be released to** - Write the name of insurance company, the name of a broker submitting on behalf of the insurance company, or third party who is not an insurer that is authorized to receive the patient's personal or health information.

Authorization of Payment

- This allows insurance company, broker or third party who is not an insurer to receive payment from Alberta Health for the health services received by the patient outside of Canada.
- **Name of payee** - write the name of the Payee which is the insurance company, broker submitting on behalf of the insurance company, or third party who is paying for the claims. This authorizes Alberta Health to pay the insurance company, broker or third party directly.

Effective Date

- The consent is only for the date range provided. **Note**: The patient can change the consent dates at any time by providing written notice to Alberta Health.
- **Departure Date** - The date the patient will leave Alberta to receive the approved health services.
- **To Date** - provide a date that is 18 months past the expected end of treatment date. The healthcare provider has up to 365 days from the date of medical service to submit a claim.

Signature

- By signing, you are declaring that the information provided on the form is true and correct to the best of your knowledge; that you authorize the sharing of the provided personal or health information for the purposes of Alberta Health reimbursing an insurance company, broker or third party for the cost of health services received by the patient while outside of Canada.
- The form **must** be signed by the Alberta resident or a duly legally authorized representative. If the form is signed by a legal representative that person must provide documentation at the time the form is submitted that identifies the specific legal relationship with the Alberta resident that allows that person to sign this form on behalf of the Alberta resident. Any documents submitted to show the legal representative's authority must be notarized copies. Notwithstanding any documentation submitted by a legal representative Alberta Health may request further confirmation as to the legal representative's authority to sign this form on behalf of the Alberta resident.

Submission

- Return a completed consent to your secondary insurance provider.
- This form must accompany the insurance claim.

Alberta Government

Insurance Claim Consent and Authorization

The information on this form is being collected and used by Alberta Health pursuant to sections 20(a) and (b) of the *Health Information Act* and section 33(c) of the *Freedom of Information and Protection of Privacy Act* for the purpose of assigning the payment of insured medical under the Alberta Health Care Insurance Plan and insured hospital services under the Hospitalization Benefits Plan to the insurer of third party named in this form. If you have questions about the collection and use of this information, please contact an Alberta Health representative toll free within Alberta at 310-000 then 780-427-1432.

Note: Failure to complete all sections of this form will result in Alberta Health not releasing health information or reimbursing an insurance claim. Proof of payment must be submitted with the insurance claim.

Patient Information

Name of Patient - please print

Alberta Personal Health Number (PHN)

PHN of Patient

Authorization for Release of Health Information

My health information can be released to:

CanAssistance Inc.

Name of insurance company, and where applicable, the name of a broker submitting on behalf of the insurance company, or third party who is not an insurer (e.g. junior hockey clubs, churches).

to permit Alberta Health for reimbursement of health benefits paid on my behalf for the cost of insured health services by the insurer or third party which I received outside of Alberta.

Authorization of Payment

I, _____ hereby assign to CanAssistance Inc.

Name of Patient

Name of Payee

any amounts payable to me by Alberta Health for out of country health benefits.

Effective Date

This consent is effective From _____ (Departure date)

Date *(yyyy-mm-dd)*

To _____ (at least 18 months from the earliest date of service to ensure sufficient time for processing). Please note: the submitter has up to 365 days from the date of medical service to submit a claim to Alberta Health.

Date *(yyyy-mm-dd)*

Declaration

I, the patient, authorize disclosure of the following information for the purposes of Alberta Health to reimbursing health benefits paid on my behalf for the cost of insured health services received outside of Alberta, which may include the following: date(s) of service(s), type(s) of service(s) and reason(s) for service(s), amount(s) paid, name(s) of service provider(s), and where applicable, the facility name, and personal health number.

I also understand I have been asked to authorize disclosure of this information so as to permit Alberta Health to reimburse the identified insurance company, or third party who is not an insurer that has paid a medical service claim on my behalf, and I am aware of the risks and benefits of consenting, or refusing to consent to the disclosure. I further understand that this consent may be revoked by submitting such revocation to the Out-of-Country Claims Unit of Alberta Health.

I, certify that the information provided above on this form is true and correct.

Please print name of person signing

Signature of person completing request (if 18 years of age and over)

- or -

Signature of authorized representative (if person completing request is under 18 years of age or wholly dependent on the authorized representative by reason of mental or physical infirmity).

Please return this completed form to secondary insurance company.

If this document is being signed by someone other than the resident or the resident's parent, the individual signing must be a legal representative of the resident and must be accompanied by notarized copies of any legal documents that establish to the satisfaction of Alberta Health the individual's legal authorization to sign on behalf of the resident.