can assistance

CLAIM FORM – VISITORS TO CANADA

CLAIMS PROCESS

A. Complete both pages of this form.
B. Sign the « Assignment of Benefits » section if applicable.
C. Sign the « Agreement and Authorization » section. If the patient is a minor, a parent or legal guardian must sign the form.

SEND THIS DULY COMPLETED FORM ALONG WITH ALL OTHER REQUIRED DOCUMENTS TO CANASSISTANCE

Online via our secure website:	*By regular mail:*
canassistance.com/en/policyholder/depot	**CanAssistance, Travel Claims Department**
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.	**PO BOX 3888, Station B, Montreal, Quebec, H3B 3L7**

INSURANCE COMPANY	GROUP NUMBER (Optional)
CONTRACT NUMBER	FILE NUMBER (Optional)

Policyholder

Last name	First name	Date of birth (Year / Month / Day)	Gender ☐ M ☐ F
Email		Telephone 1	Telephone 2
Country of origin		Relationship to patient (if different from policyholder)	

Address in Canada
no | Street | Apt. | City | Province | Postal Code

Assignment of benefits

Are eligible benefits payable to a person other than the policyholder? ☐ Yes ☐ No If yes, please specify who the cheque should be issued to.

Name and address of the person: _____

_____ _____

Signature of policyholder

Patient (if different from policyholder)

Last name	First name	Date of birth (Year / Month / Day)	Gender ☐ M ☐ F

Information about your trip

Stay in Canada

Arrival date in Canada (Year / Month / Day) | Departure date from Canada (Year / Month / Day)

Stay in the U.S.

Departure date from Canada (Year / Month / Day) | Return date to Canada (Year / Month / Day)

Reason for trip
- ☐ Vacation
- ☐ Immigration
- ☐ Studies, name of institution: _____
- ☐ Work, name of employer: _____
- ☐ Other, specify: _____

Agreement and Authorization

1. I hereby agree to assign to Canassurance Hospital Service Association and CanAssistance Inc. (hereinafter called the Insurer) all benefits payable by third parties for losses covered under the policy. Furthermore, following the application for reimbursement from CanAssistance Inc., I authorize third parties to pay CanAssistance Inc., the benefits payable regarding these losses.
2. I authorize the Insurer to provide the information contained in my claim file to third parties, for their use, within the context of this claim, to determine the benefits payable, if the case arises.
3. I authorize the Insurer to make payments pertaining to the expenses claimed, directly, when required, to any institution and/or any other provider of services.
4. To assess my application for benefits, I authorize any licensed physician, practitioner, hospital or medical institution, insurance company, or any other agency, institution or person, who have information necessary to analyze my application, to convey that information to the Insurer. I understand that said information may be disclosed when required to its reinsurers, to internal and external auditors and to any professional or organization mandated by the Insurer within the context of processing my application for benefits. This authorization is valid until the final settlement of my claim.
5. I declare that the information and details given on this form and the information provided in the attached documents are complete and true, and I am aware that any false declaration shall nullify the insurance certificate or insurance policy and shall result in the denial of my application for benefits.

Signature of Policyholder or legal heir: _____ Date : _____

Signature of Patient (if different from policyholder): _____ Date : _____

CLAIM FORM – VISITORS TO CANADA

FOR OFFICE USE

Services and care received

Date when first symptoms appeared or accident occured
Year | Month | Day

City and country where services were received

Indicate the reason why you received medical and/or hospital care

Describe services received (e.g.: examination, x-ray, surgery, etc.). Please use a separate sheet if needed.

If claiming due to an accident, please specify:

Date of accident
Year | Month | Day

Type of accident
☐ Motor vehicle ☐ Work ☐ Other, specify: _____

Amount Claimed

Amount claimed: _____

Currency:

☐ Canadian Dollars
☐ Other, specify: _____

Were bills paid?

☐ Yes
☐ No

If yes, please specify:

☐ Totally
☐ Partially _____
Paid amount

Other Insurance

Do you, your spouse or child have another travel insurance ☐ Yes ☐ No If yes, please provide the following information:

Policyholder _____ Insurance Company _____

Policy number _____ Company phone number _____

Identification number _____

Have you already initiated a claim? ☐ Yes ☐ No If yes, please indicate the file number: _____

Medical Information

If the patient consulted a doctor or specialist in the 6 months preceeding the effective date of the policy, please provide:

Physician name / Medical Facility	Telephone / Email	Nature of the illness or accident	Date of service

If the patient was hospitalized in the 12 months preceeding the effective date of the policy, please provide:

Hospital name	Telephone / Email	Nature of the illness or accident	Admission date (Year / Month / Day)
Address (city and country)			Discharge date (Year / Month / Day)

Please provide the names of all the medicines the patient was taking in the 6 months preceeding the effective date of the policy:

Essential Documents to Submit

- This duly completed and signed form.
  - If more than one person received care, you will need to complete a claim form for each person.
  - If the claim involves a person who is a minor, the policyholder or legal heir must sign the form.
- The detailed invoices and proof of payment.
  - Invoices for medical care must show the diagnosis and treatment.
  - Invoices related to the purchase of prescription medication must show the name of the drug, the dosage and the price.
  - Valid proof of payment may include a credit card statement or proof of a deposited cheque, and the currency in which the service was paid must appear. In the absence of a bank or credit card statement, a receipt may be accepted.
- Any other relevant document(s), such as medical reports, lab results, etc.

An incomplete claim may cause additional delays in processing your file. If you can't submit all requested documents, please provide us with an explanation in a letter attached to your claim. We reserve the right to request the original documents or additional information if needed. Please keep a copy of your supporting documents for your records.

Should you have any questions about your claim, please contact us by using the phone number on your insurance card or visit our website at canassistance.com.

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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 direct deposit, please complete this form and attach a voided 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.

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Policyholder identification

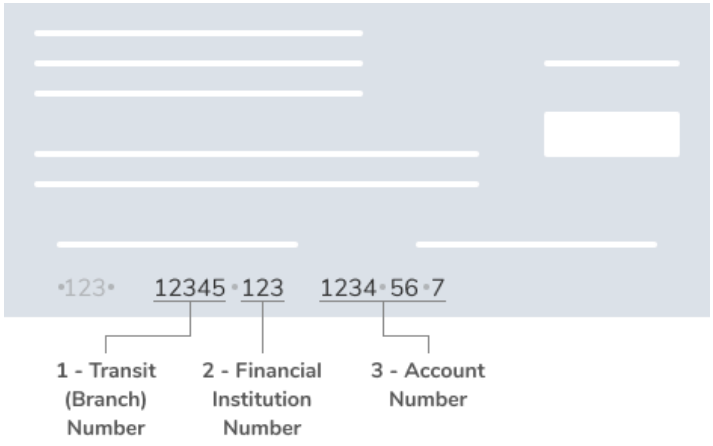
Name of the policyholder	Contract, certificate or identification number	File number

Bank Account Details (Canadian financial institutions only)

To avoid payment errors and delays, please attach a voided 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 voided cheque, 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) to the aforementioned account number.

Signature of the policyholder _____ Date _____