



**CLAIM FORM**

**NOTE:** Failure to complete this claim form in its entirety will delay reimbursement.

Please forward all correspondence, including this COMPLETED AND SIGNED CLAIM FORM to the above indicated address.

For assistance in completing this claim form, please contact our Claims Department at 1-877-344-8398, Monday through Friday (8:30AM to 5:00PM).

**IMPORTANT TO READ BEFORE COMPLETING THIS FORM**

**THE INSURER** requires the claim form within 90 days after *Your* trip return to *Your* province of residence.

**INCLUDE:**

- Original invoices and/or receipts – photocopies will not be accepted.
- Cash/Cashier receipts will not be considered for the purpose of a reimbursement or eligibility (except if provided as a proof of payment).
- A proof of your departure date is mandatory for claims submitted under an Annual Plan.
- An applicable Provincial Health Insurance form completed and signed.  
(if this form was not included with this claim form, it will be sent to you later)

Are you covered by any other private insurance (group, retired, Medicare...)?    YES     NO

Company \_\_\_\_\_ Policy no. \_\_\_\_\_

**CLAIMANT'S STATEMENT**

Name of the Insured and the address where the refund has to be sent.

\_\_\_\_\_

First \_\_\_\_\_ Last \_\_\_\_\_ # Policy No. \_\_\_\_\_

No Street Apt. # City Province Postal Code

Government Health Insurance No. \_\_\_\_\_ Telephone : (\_\_\_\_\_) \_\_\_\_\_ Date of Birth : \_\_\_\_/\_\_\_\_/\_\_\_\_  
dd mm yy

**CLAIM (Please answer all questions)**

1. a) PLEASE check the appropriate box below:

SICKNESS       ACCIDENT       OTHER   
 Treatment received in:    Office/clinic       Emergency Room of a hospital       Hospital

b) PLEASE, provide dates and brief details related to this claim.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

c) In the past, have you received treatment for those symptoms or illnesses?      YES       NO   
 If YES, PLEASE provide the dates and places of consultation.

\_\_\_\_\_

\_\_\_\_\_

2. Please indicate all prescribed or used medications in the last 12 months. If None, please check   
 (With the exception of prescriptions for menopause, vitamins and antibiotics prescribed temporarily  
 and those listed in the present claim).

_____	_____	_____
_____	_____	_____
_____	_____	_____

**CLAIM EXPENSES**

**Give the details and amount of your expenses. (Attach separate sheet if necessary)**

Name of Medical Services Provider	Date of service received dd/mm/yy	Amount billed	Amount paid by you	Currency
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	

**AUTHORIZATION**

I authorize the *Insurer* to obtain all medical information from health care organizations concerning my medical history. I specifically authorize the INSURER AND TOUR+MED Assistance Inc. to submit on my behalf, to my Provincial Government Health Insurance, in accordance with applicable laws and regulations, the claims for insured medical and hospital services I received. A copy or facsimile of this authorization shall be deemed as valid as an original.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Insured Person dd/mm/yy