ONEWORLD ASSIST

DOCUMENTATION REQUIREMENTS

EMERGENCY MEDICAL CLAIMS FOR TRAVELLING CANADIANS
BC RESIDENTS

Below is a list of required claim forms and additional information, needed to process your recent claim. Please review each item carefully and complete it as accurately and as fully as possible. Be sure to sign each form as indicated. In addition, provide all ORIGINAL receipts, bills and/or prescription receipts.

Please provide the following documents and information:

- ☑ **Excess Hospital-Medical Claim**
  - Please complete both sides of this form.
  - In Section 3, please remember to sign the bottom of this section, warranting you have disclosed all additional coverages. (Reminder: if information is incomplete or inaccurate, your claim may be null and void)
  - If you list additional coverage in Section 3, you must also sign Section 4.

- ☑ **Schedule A&B**
  - Complete and sign both Schedule A and Schedule B (both are required for the Medical Services Plan of BC).
  - This form is not required if you are ONLY claiming for any of the following*:
    - Treatment provided by: a chiropractor, physiotherapist, chiropodist, osteopath, podiatrist, acupuncturist, naturopath, holistic doctor, or
    - Prescription glasses replacement, or
    - Additional air travel related benefits, or
    - Medical expenses incurred within Canada (other than in Quebec).

    *Not all policies cover all these benefits—refer to your policy wording to determine if these are covered by your policy.

- ☑ **A photocopy of your MSP Care Card.**

- ☑ **All ORIGINAL, itemized bills/receipts.**

- ☑ **All ORIGINAL prescription drug receipts** (pharmacy issued tax or customer receipts).

- ☑ **Out-of-Country Claim Form** (If hospitalized overnight, this form is required by the Medical Services Plan of BC)
  - Complete and sign Section A only, including the Release of Information at the bottom of the section.
  - If the claim is due to an injury or a motor vehicle accident, you must complete the applicable portions of Section C.
  - If you were not hospitalized overnight, this form is not required.

- ☑ **Proof of payment**
  - If you have already paid the medical provider or facility directly, please provide proof of the amount paid so we can process your reimbursement.
  - For example, "paid" receipt from the provider, credit card statement, copy of a cancelled cheque, etc.

- ☑ **Written statement (if your claim is related to an ILLNESS)**
  - Please provide a written statement detailing the diagnosis or the nature of the illness you are claiming for.
  - Wherever possible, please include the dates and times of your consultations, and the name, address and telephone number of the physician/facility that treated you.

- ☑ **Written statement (if your claim is related to an INJURY)**
  - Please provide a written description of the event which caused your injury. Be sure to include the date and time of the incident as well as the name, address and telephone number of who you feel is responsible.
  - If possible, please also include the name, address and telephone number of the physician/facility that treated you for the injury.

In the unfortunate event you are filing a claim for someone who has passed away, please also submit:

- ☑ A copy of the Insured's Death Certificate.

- ☑ A copy of the section of the Will which designates who will be acting on behalf of the Estate (i.e. who is the Executor).

- ☑ The original receipts for cremation or for homeward carriage for burial, if these expenses were incurred while the Insured was travelling.

As we are unable to process your claim until this information is received, please provide all of the requested information as soon as possible.

Thanks for your assistance.

OneWorld Assist looks forward to resolving your claim.

ONEWORLD ASSIST

This form will be returned if not completed in full

10th Floor, 6081 No. 3 Road • Richmond, BC V6Y 2B2
Telephone: 604 278 4108 • Fax: 604 276 4593
Canada & USA Toll Free: 1 800 663 0399

Excess Hospital-Medical Claim

Claim No. ____________

Important Reminders:
- Complete all sections of the claim form(s) in full (front and back), signing where indicated.
- Include original, itemized bills, indicating dates and costs of all services provided.
- Keep copies of all bills for your records.
- By submitting this claim form, you warrant that all information provided is true, correct and complete.
- Your provincial health plan is your primary coverage. Most provincial plans have a 90-day deadline for claiming; if you fail to meet the submission deadline for your provincial plan, you will be responsible for the amount that your provincial plan would have paid.

1. GENERAL INFORMATION

Name of the Insured claiming ____ FIRST NAME ____ FAMILY NAME ____ ❍ M ❍ F

Policy number ____________ Date of birth ____ M | D | Y ____

Address ____________ City ____________ Prov. ____________

Postal code ____________ Telephone: Home [ ] ____________ Office [ ] ____________

E-mail address ____________ Fax [ ] ____________

Name of provincial health care plan and Personal Health Number ____________

Name, address and telephone number of your usual Canadian physician ____________

____

State the names of any medications you were taking prior to departure ____________

____

Departure date from home province ____ M | D | Y ____ Return date to home province ____ M | D | Y ____

Country where claim occured ____________ Currency paid ____________

Date Sickness or Injury occurred ____ M | D | Y ____

Nature and description of Sickness or Injury claimed ____________

____

2. MEDICAL AUTHORITY

AUTHORIZATION TO PHYSICIANS, HOSPITALS AND OTHER MEDICAL PROVIDERS

(This form will be returned to the sender if not completed and signed as indicated.)

1. I authorize all hospitals, physicians, medical care providers, insurers and other persons, from all countries, to provide to OneWorld Assist Inc. ("OWA") all information and documentation in their possession that OWA requires to process my claim, including: records in regard to illnesses, injuries, medical history, consultations, medicines and treatments of the claimant named below (collectively, the "Medical Records").
2. I authorize OWA to collect, use and disclose the Medical Records, and the information in the Medical Records, to the selling agent, and to any insurers, including government health plans, that may have a responsibility in this claim.
3. I understand that the purpose for the collection, use and disclosure of the Medical Records is to enable OWA and insurers to assess and determine the eligibility of any claim I might submit. I acknowledge and agree that it is my responsibility to provide to OWA such information and other documentation as may reasonably be required to process my claim and that my failure to do so will jeopardize my entitlement to coverage.
4. I understand that if Medical Records are required from the U.S., this purpose constitutes a payment operation under the privacy rules in the U.S. Health Insurance Portability and Accountability Act (HIPAA).
5. This authorization takes effect on the date set out below. I understand that I may revoke this authorization in writing. I acknowledge and agree that if this authorization is revoked before the Medical Records are collected and reviewed my entitlement to insurance coverage will be jeopardized.

A copy of this authorization received from OWA shall be as effective and valid as the original.

X ____________
Signature **(Claimant or authorized representative)**

____ FIRST NAME ____ FAMILY NAME ____
name **(and relationship if not claiment)**

____ M | D | Y ____
Date

PLEASE COMPLETE AND SIGN REVERSE SIDE

3. OTHER INSURANCE (If claimant is a dependent, provide requested information for parents or guardians.)

Do you have any group benefits available for medical coverage through your employer, your spouse's employer or a retirement plan? ___ Yes ___ No
If "Yes", please provide details below:

	Name of Insurance Co.	Telephone #	Group Policy#	Member ID#	Lifetime limit
Your employer/retirement plan	___	___	___	___	$___
Spouse's employer/retirement plan	___	___	___	___	$___

Spouse's name ___ FIRST NAME ___ FAMILY NAME ___ Spouse's date of birth ___ M | D | Y ___

Do you have benefits available through any other travel insurance company or travel supplier? ____ Yes ____No If "Yes", please provide:

Name of other provider ___ Policy #___

Address of other provider ___

Did you use a credit card for any of your travel arrangements? (many credit cards offer travel benefits) ____ Yes ____ No If "Yes", please provide:

Name of issuing financial institution ___

Card number ___ Expiry date ___

FIRST NAME FAMILY NAME ___ X ___ M | D | Y ___
Name of cardholder (please print) Cardholder signature (if different from insured) Date

I warrant that I do not have any other travel or out-of-country medical insurance coverage.

X ___ FIRST NAME FAMILY NAME ___ M | D | Y ___
Signature (claimant or authorized representative) Print name Date

4. CLAIMANT'S ASSIGNMENT OF PAYMENT

I assign to OneWorld Assist Inc. ("OWA") any benefits obtainable from other sources for covered losses. For payments made on my behalf, I authorize any other carriers to assign eligible benefits to OWA.

A copy of this authorization received from OWA shall be as effective and valid as the original.

FIRST NAME FAMILY NAME ___
Print full name (and relationship if not claimant)

X___ M | D | Y ___
Signature (claimant or authorized representative) Date

X___ M | D | Y ___
Signature of primary policy holder of other insurance in Section 3 above (if applicable) Date

BC Residents Only

For faster claim service - please complete and SIGN BOTH parts of this form (Schedule A and Schedule B) and send it with the completed Claim Form and your medical expenses/receipts to:

OneWorld Assist
10th Floor, 6081 No. 3 Road
Richmond, BC V6Y 2B2

Schedule A

ASSIGNMENT OF PAYMENT

Personal Health (CareCard) Number of Patient: ______________________

BETWEEN: ____
Assignor (Adult Patient, or Parent/Guardian of Patient)

AND: OneWorld Assist Inc.
10th Floor - 6081 No. 3 Road
Richmond, BC V6Y 2B2

AND: HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF BRITISH COLUMBIA AS REPRESENTED BY THE MINISTER OF HEALTH SERVICES, hereinafter referred to as the Minister.

WHEREAS the Assignor is a person eligible for insured services and/or benefits under the Province of *British Columbia's Medicare Protection Act* and/or *Hospital Insurance Act*, and as such may receive payment for certain of those services or benefits from the Minister.

And WHEREAS the Assignor is bound by an obligation under a contract or agreement with the Assignee to remit to the Assignee all payments received for such insured services and/or benefits from the Minister.

THEREFORE, in consideration of the obligation to the Assignee, the Assignor hereby assigns to the Assignee all sums of money that shall be owing to the Assignor by the Minister in relation to the insured services and/or benefits referred to above. The Minister is hereby authorized to pay all such sums directly to the Assignee at the address noted above, or at any address the Assignee may from time to time designate, with payment of any such sum to be a complete discharge of the Minister from any indebtedness in the amount to the Assignor, his heirs, executors, or administrators.

By signing this form, you will be assigning your MSP and hospital insurance benefit to the insurance company (Assignee) named above.

Payment assignment is effective from: ___________________________
(policy effective dates) *(YYYY/MM/DD)*

to: ___________________________
(YYYY/MM/DD)

____
Signature of Assignor (Patient or Parent/Guardian of Patient)

Date Signed ___________________________
(YYYY/MM/DD)

Schedule B

AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

Personal Health (CareCard) Number of Patient: ______________________

Name of Adult Patient, or Parent/Guardian of Patient:

____

Name of Minor-aged Patient (if applicable):

____

Address: ____

____

Telephone Number: ______________________________________

Insurance Company: OneWorld Assist

Insurance Coverage:

___________________________ to ___________________________
(YYYY/MM/DD) *(YYYY/MM/DD)*

I, the above-named adult, hereby consent to and authorize the Ministry of Health Services ("the Ministry") to provide to an authorized representative of the above-named insurance company ("the Insurer"), for the use by the Insurer in assessing entitlement to benefits, any and all records and information in the possession of the Ministry regarding claims for medical or health care services incurred while I had insurance coverage with the Insurer during the period noted above, including records and information relating to medical history and physical condition both prior and subsequent to receipt of the medical or health care services.

____
Signature of Adult (Patient or Parent/Guardian of Patient)

Date Signed ___________________________
(YYYY/MM/DD)