



## **Let's get started! We're looking forward to helping you with your claim.**

Below is the list of required documents and additional information to finalize your claim. Be sure to review each item carefully and complete it as accurately as possible.

It's best to submit your claim forms to us within 60 days from the date the claim was opened—the sooner we receive your completed claim forms, the faster we can start processing your claim.

Here's what we'll need:

- **Excess Hospital/Medical Claim Form**
  - Complete both sides.
  - Sign the bottom of Section 3 to guarantee that you have disclosed all additional coverage. Please note: if information is incomplete or inaccurate, we will not be able to process your claim.
  - If you list additional coverage in Section 3, be sure to also sign Section 4.
  - If someone is signing on your behalf, be sure to include a copy of the Power of Attorney to show that they are legally authorized to do so.
  
- **Insurance Claim Consent and Authorization**
  - This form is required for the Alberta Health Care Insurance Plan.
  - Complete the first and last sections—we will fill in the dates for you.
  - If you are *only* claiming any of the following, this form is not required:
    - Treatment provided by: a chiropractor, physiotherapist, chiropodist, osteopath, podiatrist, acupuncturist, naturopath, holistic doctor
    - Prescription glasses replacement
    - Additional air travel related benefits
    - Medical expenses incurred within Canada (other than in Quebec)

(Not all policies cover the above benefits—refer to your policy wording to check your coverage.)

- **All original, itemized bills and receipts**
  
- **All original prescription drug receipts**
  - Be sure they are the official tax receipts and not credit card or till receipts.
  
- **Proof of payment**
  - If you have already paid the medical provider or facility directly, provide proof of the amount paid so we can process your reimbursement.
  - This could be a receipt marked "paid" from the provider, a credit card statement, or a copy of a cancelled cheque.
  - If you paid by credit card, you may want to include a copy of the credit card statement showing the exchange rate and amount charged in Canadian dollars.
  
- **Written description (if your claim is related to an illness)**
  - Describe the diagnosis, symptoms, or the nature of the illness you are claiming for.

- **Written description (if your claim is related to an injury)**
  - Describe the injury and tell us how it happened.
  - Be sure to include the date and time of the incident as well as the name, phone number and email address (if possible) of the person or company you feel is responsible.

(If you need more space than what is provided on the claim form, feel free to write the above information on a separate piece of paper—any format is fine.)

In the unfortunate event that 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 indicating who is legally authorized to act on behalf of the Estate.
- If these expenses were incurred while the Insured was travelling, the original receipts for cremation or for homeward carriage for burial.

If you have any questions, feel free to call us toll free at 1-800-663-0399 or collect at 604-278-4108. You can also email us at [claims@tugo.com](mailto:claims@tugo.com).

We look forward to completing your claim as quickly as possible.

Take care,

**Claims at TuGo**

# Excess Hospital-Medical Claim



Claims at TuGo, 10th Floor, 6081 No.3 Road  
Richmond, BC Canada V6Y 2B2

Tel: 604-278-4108 Fax: 604-276-4593  
Canada & USA Toll Free: 1-800-663-0399

Claim No. \_\_\_\_\_

For office use only

(Please print clearly. This form will be returned if not completed in full.)

## 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 LAST NAME  M  F

Policy number \_\_\_\_\_ Date of birth MM|DD|YYYY

Address \_\_\_\_\_

City \_\_\_\_\_ Prov. \_\_\_\_\_ Postal code \_\_\_\_\_

Telephone Home ( ) \_\_\_\_\_ Office ( ) \_\_\_\_\_

Email \_\_\_\_\_ 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 MM|DD|YYYY Return date to home province MM|DD|YYYY

Country where claim occurred \_\_\_\_\_ Currency paid \_\_\_\_\_

Date Sickness or Injury occurred MM|DD|YYYY

Nature and description of Sickness or Injury claimed \_\_\_\_\_

## 2. MEDICAL AUTHORITY

### Authorization to physicians, hospitals, other medical providers & other insurers

1. I authorize all hospitals, physicians, medical care providers, insurers and other persons, from all countries, to provide to Claims at TuGo all information and documentation in their possession that Claims at TuGo 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") and other applicable insurance policy information.
2. I authorize Claims at TuGo 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 and other insurance policy information is to enable Claims at TuGo and insurers to assess and determine the eligibility of and other available insurance for any claim I might submit. I acknowledge and agree that it is my responsibility to provide to Claims at TuGo 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.
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 Claims at TuGo shall be as effective and valid as the original.

FIRST NAME LAST NAME

Print name (and relationship if not claimant)

X

Signature (Claimant or authorized representative)

MM|DD|YYYY

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:

	<u>Name of Insurance Co.</u>	<u>Telephone#</u>	<u>Group Policy#</u>	<u>Member ID#</u>	<u>Lifetime limit</u>
Your employer/retirement plan	_____	_____	_____	_____	\$ _____
Spouse's employer/retirement plan	_____	_____	_____	_____	\$ _____

Spouse's name FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_ Spouse's date of birth MM|DD|YYYY \_\_\_\_\_

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 \_\_\_\_\_

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_ **X** \_\_\_\_\_ MM|DD|YYYY \_\_\_\_\_  
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 \_\_\_\_\_ LAST NAME \_\_\_\_\_ MM|DD|YYYY \_\_\_\_\_  
Signature (claimant or authorized representative) (Print name) Date

**4. CLAIMANT'S ASSIGNMENT OF PAYMENT**

I assign to Claims at TuGo 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 Claims at TuGo.

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

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_  
Print name (and relationship if not claimant)

**X** \_\_\_\_\_ MM|DD|YYYY \_\_\_\_\_  
Signature (claimant or authorized representative) Date

**X** \_\_\_\_\_ MM|DD|YYYY \_\_\_\_\_  
Signature of primary policy holder of other insurance in Section 3 above (if applicable) Date

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

**Authorization for Release of Information**

I or my representative hereby authorize disclosure of the following information for the purposes of Alberta Health to process claims for the reimbursement of health benefits paid on my behalf for the cost of insured health services received outside of Alberta:

- 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.

for [redacted], Alberta Personal Health Number (PHN) [redacted].  
Name of Resident - please print PHN of resident

This information can be released to:

[redacted]  
OneWorld Assist Inc

Name of insurance company, and where applicable, also 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).

I understand I have been asked to authorize disclosure of this information for Alberta Health to reimburse the insurance company, or third party who is not an insurer that has paid a claim on my behalf, and I am aware of the risks and benefits of consenting, or refusing to consent to the disclosure.

**Effective Date**

This consent is effective from [redacted] to [redacted].  
Date (yyyy-mm-dd) Date (yyyy-mm-dd)

and may be revoked in writing by me at any time by advising the Out-of-Country Claims unit at the address on the previous page.

**Authorization of Payment**

I assign to [redacted]

Name of insurance company, broker submitting on behalf of the insurance company, or third party who is not an insurer

whatever benefits may be payable to me or on my behalf for health services obtained outside of Alberta.

**Signature**

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).

[redacted]  
Please print name of person signing

If this document is being signed by someone other than the resident or the resident's parent, the individual signing must provide notarized copies of legal documentation (e.g. power of attorney, trusteeship, proof of custody) clearly establishing the individual's relationship with the resident and authorizing that individual to consent on the resident's behalf.

For guidance in submitting a claim, see Key Information for Submitting an Insurance Claim on the first page of this document.