



DOCUMENTATION REQUIREMENTS

EMERGENCY MEDICAL CLAIMS FOR TRAVELLING CANADIANS ONTARIO 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.

- 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.

- Authorization and Release form**
 - Fully complete and sign this form (required by your Ontario Health Insurance Plan (OHIP)).
 - If your OHIP number has a 2-letter code after the number, be sure to include these letters as the version code.
 - 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.

- All ORIGINAL, itemized bills/receipts.**

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

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.

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 <u>FIRST NAME</u> _____ <u>FAMILY NAME</u> _____		Spouse's date of birth <u>M</u> <u>D</u> <u>Y</u>		

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



Authorization and Release

Claim No.

I, _____ irrevocably direct and authorize the Ontario Ministry of Health and Long-Term Care (MOHLTC) to make payment in respect of my claim for OHIP insured out-of-country health services to ONEWORLD ASSIST INC. (OWA) directly, and I hereby release and hold harmless the MOHLTC upon payment to OWA of the amount payable under the Ontario Health Insurance Act from any claims or causes of action, present or future, in connection therewith and I further agree to indemnify MOHLTC with respect to any claim or action brought against it in respect of any such payments made by MOHLTC to OWA.

I understand and acknowledge that information submitted by OWA to MOHLTC with this claim is necessary for the administration of the Ontario Health Insurance Act including to process payment for my out-of-country services claim. I hereby consent and authorize MOHLTC to directly or indirectly collect this personal information, including personal health information, from OWA for this purpose. I further consent to the disclosure by MOHLTC to OWA of any personal information, including personal information, that in the opinion of MOHLTC is required for this purpose.

Ten-digit MOHLTC number

Version code

 _____
Signature of (or on behalf of) Insured

Date

M | D | Y