

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

- o 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)).
- o 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.
- o 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.
- o 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	IoII 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.

Name of the Insured claiming	FIRS	ST NA	ИЕ			FAMILY NA	ME			0	M O
Policy number						Date of birth	M		D	Υ	
Address						City			Prov	·	
Postal code	Telepho	one: Ho	me []_			Office [] _			
E-mail address							Fax []			
Name of provincial health care plar Name, address and telephone num											
	ber of you	ır usual	Canadia	an phys	sician						
Name, address and telephone num	ber of you	r usual taking	Canadia prior to	an phys	sician ture						
Name, address and telephone num State the names of <u>any</u> medication	ber of you	r usual taking	Canadia prior to	depar	ture	Return date to h Currency paid	ome province	<u> M</u>		D	Y

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

reopy of this authorization received from overshall be as en	cetive and valid as the original.	
X	FIRST NAME	FAMILY NAME
Signature (Claimant or authorized representative)	name (and relationship if not claiment)	
M D Y		
Date		

Do you have any group benefits available for medical cov If "Yes", please provide details below:	verage through your emplo	yer, your spouse's emplo	yer or a retire	ement pla	an?	_Yes _	
Name of Insurance Co.	<u>Telephone</u> #	Group Policy#	Member ID	<u>#</u>	Lifet	time lir	mit
our employer/retirement plan					\$		
spous'e employer/retirement plan					\$		
pouse's name <u>FIRST NAME</u> FAM	ILY NAME	Spouse's date of birt	hM	[D		Υ
Do you have benefits available through any other travel	insurance company or trav	vel supplier? Yes _	No_If"	Yes", plea	ase pro	vide:	
lame of other provider		Poli	icy #				
Address of other provider							
oid you use a credit card for any of your travel arrangeme	ents? (many credit cards offe	er travel benefits)`	Yes No	o It"Yes	s", pleas	e prov	/Id
lame of issuing financial institution							
Card number		Expiry date					
		• •					
FIRST NAME FAMILY NAME	X	• •	M				
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Telephone: 604 278 4108 • Fax: 604 276 4593
Canada & USA Toll Free: 1 800 663 0399

Claine No	
Claim No.	

Authorization and Release

irrovoca	bly direct and authorize the Optorio Ministry of Health
	bly direct and authorize the Ontario Ministry of Health
and Long-Term Care (MOHLTC) to make payment in respect of my cl	aim for OHIP insured out-of-country health services
to ONEWORLD ASSIST INC. (OWA) directly, and I hereby release and $\ensuremath{^{\text{H}}}$	nold 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 proc	ess payment for my out-of-country services claim.
I hereby consent and authorize MOHLTC to directly or indirectly colle	ect 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 N	OHLTC is required for this purpose.
Ten-digit MOHLTC number	Version code
Ø1	
Signature of (or on behalf of) Insured	Date