

### Instructions

1. Complete this form and attach in full as requested.
2. Sign and date completed form and return package to:

**Group Medical Services**  
**400 University Avenue, 15th Floor**  
**Toronto, ON M5G 1S7**  
**CANADA**

For claims inquiries, please contact:

**Toll Free 1-800-459-6604 (within Canada and the USA) OR**  
**Collect (416) 260-4970 (from all other locations)**

Please attach the following documents:

- All original itemized medical bills and prescription receipts
- A photocopy of the sick/injured person's provincial health card
- Documentation confirming your departure and return dates (i.e. airline tickets, gas receipts, etc.)
- In the event that you have paid any eligible medical expenses, please provide proof of payment (i.e. credit card vouchers, cancelled cheques, etc.)

### A. Personal Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth DD / MM / YYYY  
Destination Address \_\_\_\_\_ City \_\_\_\_\_ Prov/State \_\_\_\_\_ Postal/Zip Code \_\_\_\_\_  
Destination Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_  
GMS Policy # \_\_\_\_\_ Email \_\_\_\_\_

### B. Insured Details

Name of Ill or Injured Person \_\_\_\_\_  
Provincial Health Plan Number of Claimant \_\_\_\_\_  
Departure Date DD / MM / YYYY Return Date DD / MM / YYYY \*Please attach documents confirming these dates

### C. Claim Details

Nature of Sickness or Injury \_\_\_\_\_ Date of Incident DD / MM / YYYY

Describe How Incident Occurred \_\_\_\_\_

Have you Paid any Invoices?  Yes  No If yes, provide amount paid \$ \_\_\_\_\_ Currency \_\_\_\_\_

#### Name, Address, and Telephone Number of all physicians and specialists that the claimant has seen prior to the departure date.

Name & Specialty \_\_\_\_\_ Address \_\_\_\_\_ Tel. Number ( \_\_\_\_\_ ) \_\_\_\_\_

Name & Specialty \_\_\_\_\_ Address \_\_\_\_\_ Tel. Number ( \_\_\_\_\_ ) \_\_\_\_\_

Name & Specialty \_\_\_\_\_ Address \_\_\_\_\_ Tel. Number ( \_\_\_\_\_ ) \_\_\_\_\_

Did the patient suffer symptoms, receive medical advice, treatment, investigation and/or was medication prescribed or changed for this medical condition

90 Days  180 Days  365 Days immediately before departure?  Yes  No

If yes, please describe \_\_\_\_\_

**COMPLETE REVERSE AND ATTACH ALL DOCUMENTS AS REQUESTED**

For complete coverage information, please refer to your policy.

## D. Group Medical Services Policy Information

Which Group Medical Services policy do you have? (check all that apply)  TravelStar® Single Trip Daily Medical  TravelStar® Multi-Trip Annual Medical

TravelWise Daily Emergency Medical  Individual Health Annual Travel (BasicPlan, ExtendaPlan®, OmniPlan®)  Immigrants & Visitors to Canada  StudentPlan

Group *Name of Group* \_\_\_\_\_ Policy/ID # \_\_\_\_\_

## E. Other Insurance Coverage (If the insured is a child, this section is applicable to the parent or legal guardian)

This insurance pays eligible expenses in excess of those covered by any other insurance. Therefore, if at the time of loss you have similar coverage with another provider (e.g. credit card, travel insurer, employment group health plan, private or provincial auto plan, etc.), we will coordinate benefits in accordance with the Canadian Life and Health Insurance Assurance guidelines.

Do you and your spouse or child have other travel insurance benefits?  Yes  No \* **Please provide details (attach additional information if necessary)**

Type of Plan \_\_\_\_\_ Policy/ID/Credit Card # \_\_\_\_\_

Name and Address of Bank/Credit Card or Insurance Company \_\_\_\_\_

I hereby warrant that I do not have any other travel or out-of-province medical insurance coverage (check if applicable)

## F. Certification and Authorization

The insurer, its agents, administrators and/or their designated representative(s), World Travel Protection Inc., (collectively "Group Medical Services") are obliged to collect and retain certain personal and/or health information about you in connection with your insurance coverage. They use and disclose that information only for the purposes of administering your policy/policies of insurance, providing customer service and assessing and paying claims.

- I/We authorize any licensed physician, medical practitioner, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, provincial health insurance plan and employer(s) to provide Group Medical Services, and their respective representatives employed to assist in the administration of this claim, any information, including personal information, data, or records that are in their possession/knowledge, regarding my medical history and treatment.
- I/We direct and authorize my government health insurance plan (GHIP) to make payment in respect of my claim for out-of-country health services to Group Medical Services directly and I hereby release GHIP, upon payment to Group Medical Services, from any further claim or cause of action in connection herewith.
- I/We hereby consent and authorize GHIP to directly or indirectly collect information contained in the claim and source documents pursuant to the Freedom of Information and Protection of Privacy Act and the Health Information Protection Act.
- I/We authorize Group Medical Services to coordinate the payment of benefits with any other insurance carriers which may also have a liability for this claim.
- I/We hereby authorize irrevocably Group Medical Services to make any payments, receive payments and settle with any carriers on my behalf.

I hereby consent to the collection, use and disclosure by the insurer, its agents and administrators of the personal and health information about me disclosed herein and in all documents or information provided in connection with my policy/policies of insurance for the purposes cited above.

If the undersigned is signing on behalf of any person(s), the undersigned represents to having the authority to sign on behalf of such person(s) and confirms that each of the above declaration and authorizations are also provided on behalf of such person(s) and confirms that each of the above declaration and authorizations are also provided on behalf of such person(s).

A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from date signed.

Signature of Claimant **X** \_\_\_\_\_ Claimant \_\_\_\_\_ (Print Full Name) \_\_\_\_\_ Date DD / MM / YYYY

If claimant is dependant, print full name of parent or guardian, or if claimant is deceased, print full name of executor.

## What to Expect During the Claims Process

If you have contacted the GMS emergency assistance centre, we will have arranged to have all bills sent directly to Group Medical Services. Once eligibility and payability are determined, the approved payments will be sent directly to the facilities and/or health providers.

### It is our goal to process eligible claims in a prompt manner, however, processing may be delayed for the following reasons:

- Delay in the receipt of mail from providers billing direct
- Delay in receipt of medical information from your treating or family physician
- Incomplete claim form and/or insufficient supporting documentation

### Due to variations in health billing systems between countries, you may receive invoices or reminder notices directly from the health provider.

Should you receive any such correspondence or if you have paid invoices directly, please forward these to the address indicated above.

### We request that you should not pay any medical accounts directly to the providers unless you have been advised to do so by Group Medical Services.

Should you receive any phone calls regarding your invoices, please direct the caller to (416) 260-4970 and we will provide the appropriate information.

**In order to expedite your claim, please return the completed claim form and all supporting documents as soon as possible. Failure to complete the claim form and attach requested documents will delay the processing of your claim. Please keep a copy of all submitted correspondence for your records.**