CLAIM FORM
Inpatriate Insurance

GlobalExcel[MD]

Contract/Policy No.: _____

Claim No.: _____

Send your completed form to:
Global Excel Management Inc., 73 Queen Street, Sherbrooke, QC J1M 0C9

IMPORTANT: Failure to sign both sides of this form will result in a delay of the processing of your claim.

SECTION A — PLAN MEMBER/CLAIMANT INFORMATION (Please print)

PLAN MEMBER'S INFORMATION

Last: First: Initial:

Address (number & street):

City: Province: Postal code:

Home: ( ) Work: ( )

Name of your employer: _____

Address: No. _____ Street _____ Suite no. _____ City _____

Province: _____ Postal code: _____ Telephone: ( ) _____

Group policy no.: _____ Date of birth (M/D/Y): ____ /____ /____

PATIENT'S INFORMATION

Last: First: Initial:

❑ Male ❑ Female Date of birth (M/D/Y): ____ /____ /____

Relationship to employee/plan member: ❑ Self ❑ Spouse ❑ Dependent ❑ Check if child is full-time student

SECTION B — OTHER INSURANCE INFORMATION

Group benefits plan: ❑ Yes ❑ No Name of your group benefits plan: _____

Group policy no.: _____ Identification no.: _____ Name of plan member: _____

Contact information: _____

Name of your employer: _____

Address: no. _____ Street _____ Suite no. _____ City _____

Province: _____ Postal code: _____ Telephone: ( ) _____

Credit card coverage ❑ Yes ❑ No Credit card no.: ___|___|___|___ ___|___|___|___ ___|___|___|___ ___|___|___|___

Card type/Bank: _____ Name of the cardholder: _____

Any other coverage (i.e: union, pensioner, private or other policy purchased prior to your departure)

❑ Yes ❑ No Policy no. _____

Name and address of insurance company / broker: _____

_____

Are you covered by US Medicare: ❑ Yes ❑ No Plan no.: _____ Type: ❑ A ❑ B ❑ Both

For information or help filing your claim, please call toll free 1-800-336-9224.

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

SECTION C CLAIM/INCIDENT INFORMATION

❶ **Date of incident** (M/D/Y): ____ /____ /____

❷ **Details of incident:** _____

_____

❸ **Diagnosis:** _____

❹ For a hospital admission, indicate:

Date of admission (M/D/Y): ____ /____ /____ Date of discharge (M/D/Y): ____ /____ /____

Name of Hospital: _____ Hospital - Tel.: ( ) _____

Address: _____ Fax: ( ) _____

_____

❺ For an out-patient consultation, indicate:

Doctor's Name: _____

Address: _____ Tel.: ( ) _____

_____ Fax: ( ) _____

❻ ☐ Fees paid by the Insured? ☐ Pay fees to provider?

❼ Please specify to which address to send reimbursement.

☐ Canadian ☐ Other (please specify below)

Address: _____

❽ Family physician & all other physicians consulted within the twelve months prior to the effective date of coverage:

_____

SECTION D AUTHORIZATION TO PHYSICIANS, HOSPITALS, AND OTHER MEDICAL PROVIDERS

1. I, the undersigned, hereby authorize any hospital, physician, or medical facility to send my medical information to Global Excel Management Inc. authorized representatives of the insurer. I further consent to the disclosure of this information by Global Excel Management Inc. to other sources as may be required to obtain benefits from other sources.
2. I, the undersigned, hereby assign to Royal & Sun Alliance Insurance Company of Canada and Global Excel Management Inc. any benefits obtainable from other sources for covered losses under this policy. I also direct these sources to forward payment to Global Excel Management Inc. with regard to these losses.
3. I warrant that neither I nor any Insured Person have any additional coverage through any other insurer (other than that listed above).
4. I understand that my insurance shall be void if, whether before or after the loss, any person has concealed or misrepresented any fact or circumstance concerning this claim.

Claimant's or authorized person's signature _____ **Date** _____

FOR COMPANY USE ONLY | **Fraud Verification A:** | **Fraud Verification B:**

The Insurance is underwritten by Royal & Sun Alliance Insurance Company of Canada and administered by RSA Travel Insurance Inc., operating as RSA Travel Insurance Agency in British Columbia.
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