ONEWORLD ASSIST

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.

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 Toll 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.

1. GENERAL INFORMATION

Name of the Insured claiming ____ FIRST NAME ____ FAMILY NAME ____ ❍ M ❍ F

Policy number ____________ Date of birth ____ M | D | Y ____

Address ____________ City ____________ Prov. ____________

Postal code ____________ Telephone: Home [ ] ____________ Office [ ] ____________

E-mail address ____________ 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 ____ M | D | Y ____ Return date to home province ____ M | D | Y ____

Country where claim occured ____________ Currency paid ____________

Date Sickness or Injury occurred ____ M | D | Y ____

Nature and description of Sickness or Injury claimed ____________

____

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.

X ____________ ____ FIRST NAME ____ FAMILY NAME ____
Signature **(Claimant or authorized representative)** **name** **(and relationship if not claiment)**

____ M | D | Y ____
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:

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

Spouse's name ___FIRST NAME___FAMILY NAME___ Spouse's date of birth ___M | D | Y___

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___
Name of cardholder (please print)

X ______________________
Cardholder signature (if different from insured)

___M | D | Y___
Date

I warrant that I do not have any other travel or out-of-country medical insurance coverage.

X ______________________
Signature (claimant or authorized representative)

___FIRST NAME___FAMILY NAME___
Print name

___M | D | Y___
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______________________
Signature (claimant or authorized representative)

___M | D | Y___
Date

X______________________
Signature of primary policy holder of other insurance in Section 3 above (if applicable)

___M | D | Y___
Date

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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

M | D | Y
____
Date