CLAIM FORM

GlobalExcel®

Policy No. _____

Claim No. _____

Send your completed form to:

In CANADA: Global Excel Management Inc., 73 Queen Street, Sherbrooke, QC J1M 0C9 / In U.S.A.: Global Excel Management Inc., P.O. Box 10, Beebe Plain, VT 05823

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

SECTION A — CLAIMANT INFORMATION (Please print)

PATIENT'S INFORMATION			POLICYHOLDER'S INFORMATION		
Last	First	Initial	Last	First	Initial
❑ Male ❑ Female	Date of birth (M/D/Y) ____/____/____		Address (number & street)	Date of birth (M/D/Y) ____/____/____	
Relationship: ❑ Self ❑ Spouse ❑ Dependent ❑ Check if child is full-time student			City	Province	Postal code
Provincial health number			Home: ( ) _____ Work: ( ) _____		

Family physician & all other physicians consulted within the ninety days prior to the date of departure	Diagnosis of illness or injury (while out of country)	
Country where claim occured	Date of incident (M/D/Y) ____/____/____	Currency
Trip date (M/D/Y) From: ____/____/____ To: ____/____/____	For trips exceeding 182 days, please provide proof of provincial health insurance extension.	**Please indicate on each bill whether you have paid it or not.**

SECTION B — OTHER INSURANCE INFORMATION

Patient's (or parent's) occupation ❑ Full-time employment ❑ Self-employed ❑ Student ❑ Retired ❑ Other: _____

Name of your employer: _____

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

Province _____ Postal code _____ Telephone ( ) _____

Name of spouse's employer: _____

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

Province _____ Postal code _____ Telephone ( ) _____

Employee group benefits plan ❑ Yes ❑ No Group policy no. _____ Name of covered person _____

Identification no.: _____ Name of insurance company: _____ Date of birth of insured (M/D/Y): _____

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

Card type / bank _____ Name of the cardholder _____

Any other coverage (e.g., 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

AS INDICATED IN YOUR POLICY, YOUR TRAVEL INSURANCE PLAN PROVIDES COVERAGE IN EXCESS OF YOUR PROVINCIAL HEALTH INSURANCE PLAN AND ANY OTHER APPLICABLE INSURANCE. FOR GLOBAL EXCEL MANAGEMENT INC. TO SEEK REIMBURSEMENT FROM THESE SOURCES, YOU MUST COMPLETE THE FOLLOWING SECTIONS.

SECTION C — 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 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:**

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

Appendix **A — Authorization and Release Specifications**

1. **DIRECTION AND RELEASE**

I, _____ personally or as the authorized substitute/proxy for _____ (the Insured Patient) irrevocably direct and authorize the Ontario Ministry of Health and Long-Term Care ("the Ministry") to make payment in respect of my claim, or if applicable, the Insured Patient's claim, for out-of-country health services directly to Global Excel Management Inc. ("GEM") and hereby release the Ministry, upon payment to GEM, from any further claim or cause of action in connection therewith.

Note: An authorized substitute/proxy is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.

2. **CONSENT**

I authorize the Ministry to collect my/insured patient's personal health information, consisting of:

- information relating to my/insured patient's receipt of health care services outside of Canada, and
- information relevant to the reimbursement of those services under the Health Insurance Act, R.S.O. 1990, c. H.6

from GEM, and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying my/insured patient's request for payment under the Health Insurance Act, including the details of any duplicate payment previously made to me/insured patient, to GEM.

I understand the purpose for the Ministry's collection and disclosure of this personal health information.

You have the right to refuse to sign this consent form, however, GEM and the Ministry will be unable to process your/insured patient's claim if this form is unsigned.

3. **AUTHORIZATION**

My/Insured Patient's Name: _____ Address: _____

Home Telephone: _____ Work Telephone.: _____

Signature: _____ Date: _____

YOUR/INSURED PATIENT'S ONTARIO HEALTH INSURANCE NUMBER: _____ **YOUR/INSURED PATIENT'S VERSION CODE*:** _____

Witness Name: _____ Address: _____

Home Telephone: _____ Work Telephone.: _____

Witness Signature: _____ Date: _____

Important: **Accurately completing all details will assist us in setting your/insured patient's claim promptly.** Please attach original bills or receipts when submitting your/insured patient's claim. We recommend you keep copies for your own records.

* Depending on the date your/insured patient's Ontario Health Card was issued or renewed, your/insured patient's **VERSION CODE** may be two letters, one letter, or you/insured patient may not yet have a **VERSION CODE**.

☎ For claim inquiries, call **1-800-336-9224** or **819-566-8698.**

Please complete the other side of this form.