

# Medical Claim Form

UNDERWRITTEN BY:  
Reliable Life Insurance Company & Old Republic Insurance  
Company of Canada (Hamilton, Ontario)

SUBMIT CLAIM TO: MARITIME TRAVEL INSURANCE  
c/o Pottruff & Smith Travel Insurance Brokers Inc.  
8001 Weston Road, Suite 300, Woodbridge, Ontario, L4L 9C8  
Telephone: 1-888-595-5311 Fax: 905-856-1539

IN QUÉBEC: ASSURANCE VOYAGES MARITIME  
a/s Pottruff & Smith Courtiers d'Assurance Voyage Inc.  
83 rue Turgeon, Bureau 300, Ste-Thérèse, Québec, J7E 3H7  
Téléphone : 1-888-595-5311 Téléc. : 450-434-0807

**CLAIMS WILL NOT BE PROCESSED UNTIL THE REQUIRED SECTIONS HAVE BEEN FULLY COMPLETED AND SUBMITTED WITH ALL OF THE REQUIRED DOCUMENTATION**

Please remember to complete both sides and all applicable sections of this form and submit with the original receipts for any out-of-pocket expenses incurred as well as documentation to support the diagnosis and treatment of the sickness or injury. **Incorrect or incomplete claim forms will delay settlement of the claim.**

For claims related to Travel Accident, Baggage, Personal Money and Rental Vehicle Physical Damage please download the forms from [www.maritimetravel.ca](http://www.maritimetravel.ca) or contact Maritime Travel Insurance at 1-888-595-5311.

## Claimant Information and Explanation of Loss THIS SECTION TO BE COMPLETED IN FULL BY ALL CLAIMANTS

<b>CLAIMANT 1</b> Mr/Mrs/ Miss/Ms	Insured Last Name	First Name	Birth Date D   M   Y	Amount Claimed/Currency
Policy/Confirmation Number		Government Health Insurance Plan Number		Version Code (Ontario residents)
<b>CLAIMANT 2</b> Mr/Mrs/ Miss/Ms	Insured Last Name	First Name	Birth Date D   M   Y	Amount Claimed/Currency
Policy/Confirmation Number		Government Health Insurance Plan Number		Version Code (Ontario residents)
Address for Correspondence or Claim Payments No./Street/Apt.			City	
Province	Postal Code	Home Telephone No.	Business Telephone No.	Email address
Date of Departure D   M   Y	Departure Point	Destination	Date of Return D   M   Y	Date of Sickness/Injury D   M   Y
Name of person who completed this form		Relationship to claimant		Date Claim Submitted D   M   Y
Describe in detail the cause and circumstances of the sickness or injury				
Location of sickness or injury:	City	State/Province	Country	Were you hospitalized? Yes <input type="radio"/> No <input type="radio"/>
Admission Date D   M   Y		Discharge Date D   M   Y		Date you returned to Canada D   M   Y
Did you contact the assistance provider (24 hour service) at the time of the sickness or injury? Yes <input type="radio"/> No <input type="radio"/>		Assistance File No.		Has the bill been paid? No <input type="radio"/> Yes <input type="radio"/> In Full <input type="radio"/> In Part <input type="radio"/>
Amount Paid		Have you submitted this claim to your government health insurance provider? Yes <input type="radio"/> No <input type="radio"/>		Amount Claimed/Refunded
Have you submitted this claim to any other plan? Yes <input type="radio"/> No <input type="radio"/>		Amount Claimed/Refunded		
Name of Parent or Guardian if Claimant under age 16				
Name of your spouse (if applicable)		Full name of your usual physician in your province of residence		
No./Street/Suite No. of your usual physician				
City		Province	Postal Code	Telephone No.
Were you hospitalized for this sickness/injury (or related condition(s)) in the last 12 months prior to the departure date shown in the policy application? No <input type="radio"/> Yes <input type="radio"/> If Yes, please provide name and address of hospital <input type="text"/>				

## Authorization and Release THIS SECTION MUST BE COMPLETED IN FULL BY ALL CLAIMANTS

By signing below, I hereby consent to, authorize and direct that Reliable Life Insurance Company or its representative, Pottruff & Smith Travel Insurance Brokers Inc., may recover from my Government Health Insurance Plan (GHIP) and/or any other Health Insurance carriers or entities, payments which were made to others on my behalf for out-of-province health services.

Furthermore, I agree that, pursuant to any applicable federal, provincial or territorial health insurance legislation or, in Ontario, the Personal Health Information Protection Act, 2004, as it pertains to freedom of information and protection of privacy, I hereby:

- Direct and authorize the Government Health Insurance Plan (GHIP) to make payment in respect of my claim for out-of-province health services to Reliable Life Insurance Company or its representative, and upon such payment, I hereby release GHIP from any further claim or cause of action in connection with such claim; and
- Consent to and authorize GHIP to directly or indirectly collect information contained in the claim and source documents pursuant to applicable provincial legislation; and
- Consent to the disclosure by GHIP to Reliable Life Insurance Company or its representative of such personal health information as may be necessarily required to process my claim for out-of-province health services, including the details of any payment previously made directly to me or on my behalf.

**Authorization to Physicians, Hospitals, other Health Care Practitioners, Medical Care Facilities, Insurance Carriers, any other Person who has attended or examined me and Other Sources:**

I hereby authorize and direct that you release to Reliable Life Insurance Company or its representative, Pottruff & Smith Travel Insurance Brokers Inc., any and all of my personal health information (and any other personal information as may be required to adjudicate my claim under this policy) you have regarding me, while under your professional care, including my medical history, any illness, injury, consultation, medicines or treatment and copies of all hospital and medical records. This authorization will permit Reliable Life Insurance Company to use the disclosed information for the purpose of determining my eligibility for coverage under my travel insurance policy, assessing insurance risks,

managing my claim and negotiating or settling payments to third parties. This authorization will permit Reliable Life Insurance Company's representative, Pottruff & Smith Travel Insurance Brokers Inc., to use the disclosed information for the purpose of determining my eligibility for coverage under my travel insurance policy and processing my claim. I hereby assign to Reliable Life Insurance Company any benefits obtained from other sources for losses covered under this policy. I also direct these sources to forward payment to Reliable Life Insurance Company for my claims submitted by Reliable Life Insurance Company with regard to these losses. A photocopy, facsimile or electronic copy of this authorization is acceptable. This authorization will also permit Reliable Life Insurance Company to release and share information with any or all parties noted above.

I certify that the statements and particulars given herein together with those on any accompanying documents are complete, true and correct to the best of my knowledge.

I understand that I can refuse to sign this consent form. I am aware that if my personal information is necessarily required for processing and adjudication of my claim, my refusal to sign this consent form may jeopardize my entitlement to benefits under this insurance policy. I understand that I may revoke this consent at any time by written notification to Reliable Life and/or its representative Pottruff & Smith Travel Insurance Brokers Inc. I also understand that the making of false or fraudulent statements in connection with a claim for benefits may render the certificate of insurance or the policy void.

Date of Consent D   M   Y	End Date of Consent: 12 Months from Date of Signature
<b>CLAIMANT 1</b> Signature of Insured / Insured's Guardian	Date of Signature D   M   Y
<b>CLAIMANT 2</b> Signature of Insured / Insured's Guardian	Date of Signature D   M   Y

## Government Health Insurance Plan Section (GHIP) AUTHORIZATION & RELEASE

**IMPORTANT: ENSURE THAT ALL SECTIONS ARE FULLY COMPLETED EVEN IF THE ANSWER IS N/A (Non Applicable)**

**RESIDENTS OF B.C. AND ONTARIO:**  
You must complete and sign the Government Health Insurance Plan (GHIP) Authorization and Release section provided ON THE OPPOSITE SIDE OF THIS FORM.

**SASKATCHEWAN AND QUÉBEC RESIDENTS:**  
Please ensure to also include with this claim form the appropriate GHIP forms. You can contact the Maritime Travel Insurance Customer Service Centre at 1-888-595-5311 to obtain the required GHIP Authorization and Release form.

**ALL CLAIMANTS:**  
Must complete and sign the Authorization and Release section IMMEDIATELY ABOVE.

GHIP SECTION CONTINUES ON BACK

FOR OFFICE  
USE ONLY

## Coverage With Other Insurers and Other Sources THIS SECTION TO BE COMPLETED IN FULL BY ALL CLAIMANTS

You may have travel protection through other sources such as a credit card or your employer. We require the following information in order to coordinate benefits with these sources.

Do you have any travel protection with any of your credit cards? Yes <input type="radio"/> No <input type="radio"/>	Credit Card No. (First 6 Digits)	Specific Card Type (i.e., CIBC Platinum, VISA)	Name of Cardholder	
Employee Group Benefits Plan Or Retired Employee Group Benefits Plan Yes <input type="radio"/> No <input type="radio"/>	Group Policy No.	Name of Covered Person	Identification No.	Name of Insurance Company
Any other coverage (i.e., Union, Pensioner, Private or Other Policy or Other Sources of Recovery) under which you are entitled to benefits? Yes <input type="radio"/> No <input type="radio"/>				Policy No.
Name and Address of Insurance Company/Broker				
Other Sources: Name and Address of Company				
Claimant's (or Parent's) Occupation Full Time Employment <input type="radio"/> Self Employed <input type="radio"/> Part Time Employment <input type="radio"/> Student <input type="radio"/> Retired <input type="radio"/> Unemployed <input type="radio"/> Other:				
Name of your Employer		Address: No./Street/Suite No.		
City	Province	Postal Code	Telephone No.	
Name of Spouse's Employer		Address: No./Street/Suite No.		
City	Province	Postal Code	Telephone No.	
Was the medical emergency caused by an accident? No <input type="radio"/> Yes <input type="radio"/>	Please provide the contact information for the responsible third party	Name	Address	Telephone No.

## RESIDENTS OF BRITISH COLUMBIA: THIS SECTION MUST BE COMPLETED PRIOR TO ANY MEDICAL CLAIM PAYMENTS Government Health Insurance Plan (GHIP) Authorization and Release section

### AUTHORIZATION TO PROVIDE MEDICAL INFORMATION AND ASSIGNMENT OF PAYMENT TO INSURED PERSON OR BENEFICIARY UNDER THE MEDICARE PROTECTION ACT OR HOSPITAL INSURANCE

BETWEEN \_\_\_\_\_ of the first part hereinafter referred to as the Assignor  
AND RELIABLE LIFE INSURANCE COMPANY C/O POTTRUFF & SMITH TRAVEL INSURANCE BROKERS INC. 8001 WESTON RD, STE. 300, WOODBRIDGE, ONTARIO L4L 9C8 of the second part, hereinafter referred to as the Assignee  
AND HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF BRITISH COLUMBIA AS REPRESENTED BY THE MINISTER OF HEALTH hereinafter referred to as the Minister

WHEREAS the Assignor is a person eligible for insured services or benefits or both under the Province of British Columbia's Medicare Protection Act or Hospital Insurance Act or both, and as such may receive payment for the above services from the Minister.

And WHEREAS the Assignor is under a covenant or obligation under a contract with the Assignee to remit to the Assignee all such payments received for medical services from the Minister.

NOW WITNESSETH THAT in consideration of the said obligation to the Assignee the Assignor hereby assigns unto the Assignee all sums of money that shall be owing to the Assignor by the Minister for the above noted contract. The Minister is hereby authorized to pay all such sums directly to the Assignee at the address aforesaid, or at any address the Assignee may from time to time designate, with payment of any such sum to be sufficient discharge to the Minister of and from any indebtedness in that amount to the Assignor, his heirs, executors, or administrators.

I HEREBY CONSENT TO AND AUTHORIZE THE MINISTRY OF HEALTH TO FURNISH ANY REPRESENTATIVE OF RELIABLE LIFE INSURANCE COMPANY ANY AND ALL RECORDS AND INFORMATION IN THE MINISTRY OF HEALTH'S POSSESSION REGARDING CLAIMS FOR MEDICAL SERVICES INCURRED WHILE I HAD INSURANCE COVERAGE FOR THE ASSIGNMENT PERIOD INCLUDING MEDICAL HISTORY AND PHYSICAL CONDITION BOTH PRIOR AND SUBSEQUENT TO RECEIPT OF MEDICAL SERVICES, REGARDLESS OF LAPSED TIME AND BEARING IN ANY WAY ON THE SERVICES RECEIVED DURING THE ABOVE TIME PERIOD.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ Signature of Assignor

Assignment Effective From: D M Y To: D M Y Personal Healthcard No.

Witness Signature Occupation

No./Street/Suite No.

City Province Postal Code Telephone No.

## RESIDENTS OF ONTARIO: THIS SECTION MUST BE COMPLETED PRIOR TO ANY MEDICAL CLAIM PAYMENTS Government Health Insurance Plan (GHIP) Authorization and Release section

### AUTHORIZATION TO PROVIDE MEDICAL INFORMATION AND ASSIGNMENT OF PAYMENT TO INSURED PERSON OR BENEFICIARY UNDER THE MEDICARE PROTECTION ACT OR HOSPITAL INSURANCE

#### 1. DIRECTION AND RELEASE

I, \_\_\_\_\_ irrevocably direct and authorize the Ontario Ministry of Health and Long-Term Care ("the Ministry") to make payment in respect of my claim for out-of-country health services to Reliable Life Insurance Company directly and I hereby release OHIP, upon payment to Reliable Life Insurance Company from any further claim or cause of action in connection therewith.

#### 2. CONSENT

##### If providing consent for self:

I authorize the Ministry to collect my personal health information, consisting of:

- information relating to my 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 Reliable Life Insurance Company, and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying my request for payment under the Health Insurance Act, including the details of any duplicate payment previously made to me, to Reliable Life Insurance Company.

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

I understand that I can refuse to sign this consent form.

##### If providing consent on behalf of a person who is not capable of consenting to the collection, use and disclosure of personal health information:

I, \_\_\_\_\_ am the substitute decision-maker for \_\_\_\_\_. I authorize the Ministry to collect personal health information about the Insured Person, consisting of:

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

from Reliable Life Insurance Company, and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying my request for payment under the Health Insurance Act, including the details of any duplicate payment previously made to me, to Reliable Life Insurance Company.

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

I understand that I can refuse to sign this consent form.

**Note:** A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.

#### 3. AUTHORIZATION

My Name	Witness Name		
Address	Address		
Home Telephone No.:	Work Telephone No.:	Home Telephone No.:	Work Telephone No.:
Signature	Date D M Y	Signature	Date D M Y