IMPORTANT NOTICE

A duly completed and signed claim form is necessary even if you have not made any payments. Your provincial health plan covers partially some of the fees for medical care received during your trip. CanAssistance reimburses these fees in full and will collect the amount payable on your behalf.

Filing a claim

Complete and sign the claim form

- Each person who received healthcare services must complete a claim form.

Attach the following documents:

- Original itemized bills for all healthcare services received, the diagnosis and treatment must appear clearly.
- Original prescription drug receipts showing the name of the drug, the dosage and the price.
- Proof of payment for all expenses claimed, such as a credit card statement or proof of a deposited cheque showing the currency in which the service was paid. In the absence of a bank or credit card statement, a receipt may be accepted.
- Proof of your departure and return dates, such as a plane ticket, a stamped copy of your passport, a bank or credit card statement showing purchases made in Canada just before your departure date and immediately after your return.
- Any other relevant document(s), such as medical reports, lab results, etc.

Send the duly completed forms and all other required scanned documents online via our secure website:

canassistance.com/en/policyholder/depot

We reserve the right to request the original documents up to one year from the date of submission of your claim.

Or send the forms and original claims documents by mail to:

CanAssistance
Travel Claims Departement
1981, McGill College Avenue, Suite 400
Montreal, Quebec, H3A 2W9

Additional Information

You may make copies of all submitted documents for your files, as they will not be returned.

Your claim will be reviewed as quickly as possible once we have received the required documents. The following situations may increase the time it takes us to process your claim:

- An incomplete claim form or missing document
- Delayed or missing detailed invoice
- Delayed or missing medical information

Eligible expenses are reimbursed in Canadian funds by cheque made out to the Primary plan member. If you are covered by more than one travel insurance policy, indicate this on your claim form. We will work with the other issuer to coordinate your benefits as needed.

If you receive a bill, please do not make any payments directly to the service provider unless we instruct you to do so. Simply send it to the address above.

Should you have any questions about your claim, please contact us by using the phone number on your insurance card or by email at claims@canassistance.com.

Disclaimer: Email is not a secure method of communication and should only be used for the transmission of non-confidential information.

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TRAVEL INSURANCE CLAIM FORM

POLICY/ ID NUMBER

PATIENT INFORMATION (please complete separate form for each person)

PROVINCIAL HEALTH NUMBER	LAST NAME	LAST NAME AT BIRTH (if different)
	FIRST NAME	DATE OF BIRTH (YEAR / MONTH / DAY) — SEX ☐ M ☐ F

PERMANENT ADDRESS IN CANADA

	POSTAL CODE	TELEPHONE NO.	HOME (AREA CODE)	WORK (AREA CODE)

STAY OUTSIDE CANADA/PROVINCE

DATE OF DEPARTURE (YEAR / MONTH / DAY) — DATE OF RETURN: (REAL OR PLANNED) (YEAR / MONTH / DAY)

REASON FOR TRIP

- ☐ VACATION
- ☐ WORK — NAME OF EMPLOYER:
- ☐ STUDIES — INCLUDE A WRITTEN CERTIFICATE FROM THE INSTITUTION:
- ☐ OTHER — DESCRIBE:

SERVICES AND CARE RECEIVED

INDICATE THE REASON WHY YOU RECEIVED MEDICAL OR HOSPITAL SERVICES:

DESCRIBE THE CARE RECEIVED (E.G.: EXAMINATION, X-RAYS, SURGERY, ETC.) IF SPACE IS INSUFFICIENT, ATTACH ANOTHER SHEET.

CITY AND COUNTRY WHERE THE SERVICES WERE RECEIVED:

IN THE CASE OF AN ACCIDENT, INDICATE:

DATE OF THE ACCIDENT (YEAR / MONTH / DAY) — TYPE OF ACCIDENT: ☐ TRAFFIC ☐ WORK RELATED ☐ OTHER (SPECIFY):

HAVE THE BILLS BEEN PAID? ☐ YES ☐ NO **IF YES:** ☐ IN FULL ☐ PARTLY

AMOUNT PAID

CURRENCY ☐ CANADIAN DOLLARS ☐ OTHER (SPECIFY):

DO YOU HAVE OTHER INSURANCE COVERING THESE COSTS? ☐ YES ☐ NO

IF YES: INSURER'S NAME: POLICY NO. :

IF THAT COVERAGE IS FROM YOUR CREDIT CARD, PLEASE INDICATE YOUR CREDIT CARD NUMBER:

MEDICAL INFORMATION BEFORE DEPARTURE

DOCTOR AND SPECIALIST (IF APPLICABLE) IN CANADA BEFORE DEPARTURE :

NAME ADDRESS

NATURE OF ILLNESS : DATE OF LAST VISIT : (YEAR / MONTH / DAY)

HAVE YOU BEEN HOSPITALIZED IN CANADA IN THE LAST 6 MONTHS PRIOR TO YOUR TRIP ? ☐ YES ☐ NO

NATURE OF ILLNESS

NAME OF HOSPITAL CITY

ADMISSION DATE (YEAR / MONTH / DAY) FILE NUMBER:

LIST THE MEDICATION(S) YOU WERE TAKING DURING THE 6-MONTH PERIOD PRECEDING YOUR DEPARTURE :

CONSENT AND AUTHORIZATION

1. I AUTHORIZE CANASSISTANCE INC. AND ITS SIGNING OFFICERS AS MY ATTORNEYS TO RECEIVE IN MY NAME AND ENDORSE AND NEGOTIATE ON MY BEHALF, CHEQUES AND OTHER FORMS OF PAYMENT FROM MY PROVINCIAL OR TERRITORIAL HEALTH INSURANCE PLAN FOR THE REIMBURSEMENT OF CLAIMS RELATING TO HOSPITAL AND MEDICAL SERVICES INCURRED DURING A TRIP OUTSIDE MY PLACE OF RESIDENCE DURING MY COVERAGE PERIOD, INCLUDING ANY AUTHORIZED EXTENSION OF SUCH COVERAGE, AND IN ACCORDANCE WITH MY TRAVEL INSURANCE PLAN.
2. I IRREVOCABLY DIRECT AND AUTHORIZE MY PROVINCIAL OR TERRITORIAL HEALTH INSURANCE PLAN TO MAKE PAYMENT IN RESPECT OF MY CLAIM FOR HEALTH SERVICES INCURRED DURING SUCH TRIP TO CANASSISTANCE INC. DIRECTLY AND I HEREBY RELEASE MY PROVINCIAL OR TERRITORIAL HEALTH INSURANCE PLAN, UPON PAYMENT TO CANASSISTANCE INC. FROM ANY FURTHER CLAIM OR CAUSE OF ACTION IN CONNECTION THEREWITH.
3. I HEREBY CONSENT AND AUTHORIZE CANASSISTANCE INC. AND MY PROVINCIAL OR TERRITORIAL HEALTH INSURANCE PLAN TO DIRECTLY OR INDIRECTLY COLLECT INFORMATION CONTAINED IN THE CLAIM AND SOURCE DOCUMENTS PURSUANT TO APPLICABLE PROVINCIAL LEGISLATION.
4. I CONSENT TO THE DISCLOSURE BY MY PROVINCIAL OR TERRITORIAL HEALTH INSURANCE PLAN TO CANASSISTANCE INC. OF SUCH PERSONAL INFORMATION AS MAY BE NECESSARILY REQUIRED FOR THE PROCESSING OF MY CLAIM FOR SUCH HEALTH SERVICES, INCLUDING THE DETAILS OF ANY DUPLICATE PAYMENT PREVIOUSLY MADE DIRECTLY TO ME.
5. I HEREBY AGREE TO ASSIGN TO CANASSISTANCE INC. ALL BENEFITS PAYABLE BY THIRD PARTIES FOR LOSSES COVERED UNDER THE POLICY. FURTHERMORE, FOLLOWING THE APPLICATION FOR REIMBURSEMENT FROM CANASSISTANCE INC., I AUTHORIZE THIRD PARTIES TO PAY CANASSISTANCE INC., THE BENEFITS PAYABLE REGARDING THESE LOSSES.
6. I AUTHORIZE CANASSISTANCE INC. TO PROVIDE THE INFORMATION CONTAINED IN MY CLAIM FILE TO THIRD PARTIES, FOR THEIR USE, WITHIN THE CONTEXT OF THIS CLAIM, TO DETERMINE THE BENEFITS PAYABLE, IF THE CASE ARISES.
7. I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND I HEREBY AUTHORIZE ANY LICENSED PHYSICIAN, PRACTITIONER, HOSPITAL OR MEDICAL INSTITUTION, INSURANCE COMPANY, MY PROVINCIAL OR TERRITORIAL HEALTH INSURANCE PLAN, THE MEDICAL INFORMATION BUREAU OR ANY OTHER AGENCY, INSTITUTION OR PERSON WHO HAS INFORMATION OR DOCUMENTS ABOUT ME OR A MEMBER OF MY FAMILY, OR MY STATE OF HEALTH OR THAT OF A MEMBER OF MY FAMILY (INCLUDING ALL PREVIOUS MEDICAL REPORTS) TO CONVEY THAT INFORMATION OR FORWARD THOSE DOCUMENTS TO CANASSISTANCE INC.

A PHOTOCOPY OF THIS AUTHORIZATION AS SIGNED BY ME, MY PARENT, GUARDIAN OR AUTHORIZED ATTORNEY SHALL BE AS VALID AS THE ORIGINAL.

SIGNATURE OF PATIENT OR PATIENT'S PARENT, GUARDIAN OR AUTHORIZED ATTORNEY | PRINT NAME | DATE (yy-mm-dd)

PRIMARY PLAN MEMBER (IF DIFFERENT FROM THE PATIENT)

LAST NAME	FIRST NAME	AGE

PROVINCIAL HEALTH NUMBER: TELEPHONE: HOME WORK

CANASSISTANCE - TRAVEL CLAIMS DEPARTMENT
1981, MCGILL COLLEGE AVENUE, SUITE 400, MONTREAL, QUEBEC, H3A 2W9 - CANASSISTANCE.COM/EN/POLICYHOLDER/DEPOT

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REQUEST FOR PAYMENT BY DIRECT DEPOSIT

IMPORTANT NOTICE

If your claim is deemed admissible, by default a cheque will be sent to the policyholder. If you prefer to receive the reimbursement in your chequing account through the direct deposit option, please complete this form and attach a sample cheque.

We recommend that you select direct deposit for a number of reasons:

- Avoid the many possible delays that come with receiving cheques by mail.
- Access your funds immediately without any holds that may be required by your financial institution.

Online via our secure website: **canassistance.com/en/policyholder/depot** Send all scanned documents and keep originals. We reserve the right to request the original documents up to one year from the date of submission of your claim.	*By regular mail :* **CanAssistance, Travel Claims Department** **1981, McGill College Avenue, Suite 400, Montreal, Quebec H3A 2W9**

Policyholder identification

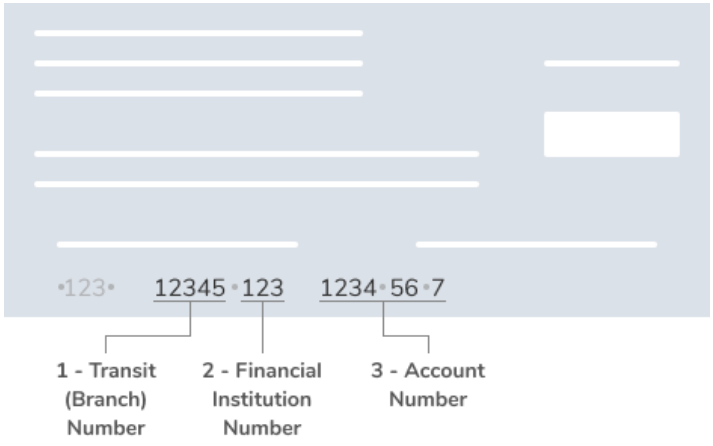
Name of the policyholder	Identification number	File number

Bank Account Details (Canadian financial institutions only)

To avoid payment errors and delays, please attach a sample cheque. A copy can also been obtained through the online banking services of your financial institution.

Scan the document or take a photo of it, making sure all information is legible.

If you are unable to provide a sample check, please carefully complete the sections below.



Branch number _____

Institution number _____

Account number _____

I hereby request that my benefits be paid via electronic funds transfer (direct deposit) into the aforementioned account number.

Signature of the policyholder _____ Date day / month / year _____