

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 this claim and all required documents by email at bluecross@canassistance.com

Or by mail: CanAssistance

Travel Claims Department PO BOX 3888, Station B Montreal, Quebec, H3B 3L7

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 our customer service toll-free at 1-866-330-3633 or at 1-306-667-5299, Monday through Friday from 8:30 am to 8:00 pm (EST) or by email at bluecross@canassistance.com.

08CAN0037A (19-11)



TRAVEL INSURANCE CLAIM FORM

POLICY / ID NUMBER	

PATIENT INFORMATION (please co	mplete separate form	n for each	person)						
PROV. HEALTH INS. CARD NO.	LAST NAME				LAST NAME AT BIRTH (if different)				
	FIRST NAME				DATE OF BIRTH YEAR MONTH DAY SEX				
							MF		
PERMANENT ADDRESS IN CANADA									
	POSTAL CODE		TEL EDUCATE NO	HOME AREA	A CODE	AREA CODE WORK			
L			TELEPHONE NO.	HOME		WORK			
STAY OUTSIDE CANADA/PROVINCE DAY MONTH YEAR DAY MONTH YEAR									
DATE OF DEPARTURE DATE OF RETURN: (REAL OR PLANNED)									
REASON FOR TRIP									
VACATION									
WORK NAME OF EMPLOY		LIE INOTITUT	ION:						
STUDIES INCLUDE A WRITTE OTHER DESCRIBE:	EN CERTIFICATE FROM TI	HE INSTITUT	ION.						
SERVICES AND CARE RECEIVED INDICATE THE REASON WHY YOU RECE	 IVED MEDICAL OR HOSPI	TAL SERVICI	ES:						
DESCRIBE THE CARE RECEIVED (E.G.: EXAMINATION, X-RAYS, SURGERY, ETC. IF SPACE IS INSUFFICIENT, ATTACH ANOTHER SHEET.									
			CITY AN) COUNTRY	WHERE THE SERVICES WEI	RE RECEIVED:			
IN THE CASE OF AN ACCIDENT, INDICAT	E: 1	TYPE OF ACC	DIDENT:						
DATE OF THE ACCIDENT	MONTH TEAR	TRAFFIC			OTHER (SPECIFY):				
HAVE THE BILLS BEEN PAID? YES NO IF YES: IN	FULL PARTLY	AMOUNT F	PAID	CURRENCY	DIAN OTHER				
DO YOU HAVE OTHER INSURANCE COVE		YES	NO	☐ DOLLA	RS (SPECIFY): —				
IF YES: INSURER'S NAME:					OLICY NO. :				
IF THAT COVERAGE IS FROM YOUR CRE		ATE YOUR C	CREDIT CARD NUMB	ER:					
MEDICAL INFORMATION BEFORE DOCTOR AND SPECIALIST (IF NECESSAF		DEPARTURE	:						
NAME		ADDRESS	s						
NATURE OF ILLNESS :					DATE OF LAST VIS	DAY MON	TH YEAR		
HAVE YOU BEEN HOSPITALIZED IN CANA	ADA IN THE LAST 6 MONT	HS PRIOR TO	O YOUR TRIP ?	YES [NO				
NATURE OF ILLNESS									
NAME OF HOSPITAL					CITY				
DAY MOI	NTH YEAR	EII E	NIIMBED-						
ADMISSION DATE L									
PATIENT'S AUTHORIZATION									
I AUTHORIZE CANASSURANCE HOSPITAL NEGOTIATE ON MY BEHALF, CHEQUES A TO HOSPITAL AND MEDICAL SERVICES INCLUDING AND AUTHORIZED SYNTHESIS	ND OTHER FORMS OF PAYM INCURRED DURING A TRIP	ENT FROM MY	PROVINCIAL OR TERF	RITORIAL HEAL	LTH INSURANCE PLAN FOR THE	E REIMBURSEMENT OF CL	AIMS RELATING		
INCLUDING ANY AUTHORIZED EXTENSION OF SUCH COVERAGE. 2. I IRREVOCABLY DIRECT AND AUTHORIZE MY PROVINCIAL HEALTH INSURANCE PLAN TO MAKE PAYMENT IN RESPECT OF MY CLAIM FOR HEALTH SERVICES INCURRED DURING SUCH TRIP TO CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND CANASSISTANCE INC. DIRECTLY AND I HEREBY RELEASE MY PROVINCIAL HEALTH INSURANCE PLAN, UPON PAYMENT TO									
CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND CANASSISTANCE INC. FROM ANY FURTHER CLAIM OR CAUSE OF ACTION IN CONNECTION THEREWITH AND I FURTHER INDEMNIFY MY PROVINCIAL HEALTH INSURANCE PLAN IN RESPECT OF SUCH PAYMENTS TO CANASSURANCE HOSPILA ERVICE ASSOCIATION.									
3. I HEREBY CONSENT AND AUTHORIZE MY PROVINCIAL 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 HEALTH INSURANCE PLAN TO CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND 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 CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL, PROVIDER INSURANCE COMPANY OR PRE-PAYMENT ORGANIZATION WHO HAS ATTENDED OR EXAMINED ME OR MY FAMILY MEMBERS TO FURNISH TO CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND CANASSISTANCE INC. OR FOR THE PURPOSES OF COORDINATION OF BENEFITS ANY AND ALL INFORMATION REQUIRED IN CONNECTION WITH THIS CLAIM, INCLUDING INFORMATION WITH									
AND CANASSISTANCE, INC. OR FOR THE PURPOSES OF COORDINATION OF BENEFITS ANY AND ALL INFORMATION REQUIRED IN CONNECTION WITH THIS CLAIM, INCLUDING INFORMATION WITH RESPECT TO SICKNESS, INJURY, MEDICAL HISTORY, CONSULTATIONS, MEDICINES, OR TREATMENT AND COPIES OF ALL HOSPITAL RECORDS FOR ME OR MY FAMILY MEMBERS. A PHOTOCOPY OF THIS AUTHORIZATION AS SIGNED BY ME. MY PARENT. GUARDIAN OR AUTHORIZED ATTORNEY SHALL BE AS VALID AS THE ORIGINAL.									
	SILES OF ME, MIT PARENT, C	-20 II VDIN OK	THORIZED ATTORN	OHALL DE A	STATE ON THE ONGINAL.				
SIGNATURE OF PATIENT				PRINT NAME		DATE			
GUARDIAN OR AUTHORIZED ATTORNEY									
PRIMARY PLAN MEMBER (IF DIFFE LAST NAME	RENT FROM THE PA	ATIENT)	FIRST NAME				AGE		
TV Wiles			I INOT NAME						
PROV. HEALTH INS. CARD NO.:			TELEPHONE: HO	ME ——	wo	ORK			

ATTENTION: READ CAREFULLY

PLEASE COMPLETE AND SIGN THE CLAIM FORM, SEND IT ALONG WITH ALL REQUIRED DOCUMENTS BY EMAIL AT **BLUECROSS@CANASSISTANCE.COM** OR BY MAIL TO THE FOLLOWING ADDRESS:

CANASSISTANCE TRAVEL CLAIMS DEPARTMENT PO BOX 3888, STATION B MONTREAL (QUEBEC) H3B 3L7