canada life™

OUT-OF-COUNTRY/PROVINCE & AUTHORIZATION FORM

ASSURED ASSISTANCE INC.

Claim # (if known)

Please complete all sections in full and mail, with original receipts, to: **Claims Department – Assured Assistance Inc.** **PO Box 97 Station A Mississauga ON L5A 2Y9**	**www.canadalife.com** **Tel: 1.866.530.6025 or 905.816.1990** **Fax: 905.813.4701**

Please complete all sections in full. Please print clearly

SECTION A: INFORMATION ABOUT THE CLAIM Please submit a SEPARATE form for each Patient

1. INFORMATION ABOUT THE EMPLOYEE Policy/Plan #: _____ Division #: _____

Subscriber #: _____ Policy Holder/Company Name: _____

Employee's Last Name: _____ First Name: _____

Number: _____ Street: _____ Apt.#: _____ City: _____ Province: _____

Postal Code: _____ Telephone: Home:( ) _____ Business:( ) _____ Ext: _____

2. INFORMATION ABOUT THE PATIENT

Patient's Last Name: _____ First Name: _____

Patient's Date of Birth: Month ( ) Day ( ) Year ( ) Relationship to Employee: _____

Government Health Insurance Plan #: _____ Version Code: _____ Province: _____

If claim is for a child age 22 or older, indicate: ☐ Handicapped ☐ Student

If Student, give name of school or university: _____

3. INFORMATION ABOUT THE OCCURRENCE

Month ( ) Day ( ) Year ( ) / Month ( ) Day ( ) Year ( ) / Month ( ) Day ( ) Year ( )

Departure Date: Return Date: Date of Occurrence:

Location of Occurrence: (City, Country) _____ Total Amount Claimed & Currency: _____

Diagnosis: _____

Name of your Canadian Physician(s): _____

Address: _____ Tel: ( ) _____ Fax: ( ) _____

SECTION B: AUTHORIZATION TO PHYSICIANS, HOSPITALS AND OTHER MEDICAL PROVIDERS AND SPECIAL AUTHORIZATION AND DIRECTION

1. I authorize you to give Assured Assistance Inc. on behalf of The Canada Life Assurance Company any and all information you have regarding me, while under observation or treatment by you, including my medical history, diagnoses and test results, and I hereby consent to the disclosure of such information by Assured Assistance Inc. to other sources as may be required for the processing of my claim for benefits obtainable from other sources.

2. I hereby assign to Assured Assistance Inc, on behalf of The Canada Life Assurance Company any benefits obtainable from other sources for losses covered under this group policy/plan. I also direct these sources to forward payment to Assured Assistance Inc. for my claims submitted by Assured Assistance Inc. on behalf of The Canada Life Assurance Company with regard to these losses.

3. A photocopy or faxed copy of this authorization is acceptable.

Date: Month ( ) Day ( ) Year ( ) Claimant or Legal Guardian's Signature: _____

SECTION C: PROVINCIAL GOVERNMENT HEALTH INSURANCE (GHIP) AUTHORIZATION AND RELEASE (to be completed if you do not reside in the Province of Quebec)

I authorize Assured Assistance Inc. and its signing officers on behalf of The Canada Life Assurance Company as my attorneys to receive in my name and endorse and negotiate on my behalf cheques from my Provincial Government Health Insurance Plan to reimburse claims paid on my behalf by Assured Assistance Inc. relating to hospital and physician services while I was outside my province of residence. I direct my Government Health Insurance Plan to forward payment to Assured Assistance Inc. on behalf of The Canada Life Assurance Company for my claims submitted on my behalf.

Date: Month ( ) Day ( ) Year ( ) Claimant or Legal Guardian's Signature: _____

Date: Month ( ) Day ( ) Year ( ) Witness Signature: _____

SECTION D: POWER OF ATTORNEY (to be completed if you reside in the Province of Quebec)

I, the undersigned (Print in block letters) _____ empower Assured Assistance Inc. on behalf of The Canada Life Assurance Company to:

1) submit to the Régie de l'assurance-maladie du Québec (the Régie) in accordance with the laws and regulations applied by the Régie, my claims for insured medical and hospital services which I, my spouse or my children (family insurance) received in (country/state/city) _____ during our stay from (Date): _____ to (Date): _____

FAMILY INSURANCE: For the purpose of family insurance, this Power of Attorney covers, in addition to myself, only my spouse and my children identified below:

1. Spouse _____ H.I. No. _____
2. Children _____ H.I. No. _____

_____ H.I. No. _____

2) transmit to, receive from the Régie all information and documents required for the assessment and payment of said claims

3) receive from the Régie all amounts reimbursed and due to me, my spouse or my children (family insurance)

I authorize the Régie to accept the claims so submitted, to act in accordance with the Power of Attorney as specified and to transmit to the company any and all information it may request concerning the beneficiary status of myself, my spouse or my children.

Beneficiary's Signature: _____ Beneficiary's Health Insurance No.: _____

SECTION E: OTHER INSURANCE COVERAGE

Do you have other coverage through: (please check all that apply)

☐ Spouse's Employer/Retiree Plan

Spouse's Last Name: _____ First Name: _____ Name of Insurer: _____

Policy Plan #: _____ Division#: _____ Certificate#: _____ Employer/Company Name: _____

☐ Credit Card(s)

1. Card Company: _____ Card Number: _____ Expiry Date: _____
2. Card Company: _____ Card Number: _____ Expiry Date: _____

☐ Home/Auto Insurance

Policy/Plan #: _____ Name of Insurer: _____

☐ Travel

Policy/Plan #: _____ Name of Insurer: _____

☐ Other – Please Specify Type: _____

Policy/Plan #: _____ Name of Insurer: _____

☐ I do not have other out-of-country/province medical coverage.

Date: Month ( ) Day ( ) Year ( ) Claimant or Legal Guardian's SIgnature: _____

Clear