

## EMERGENCY MEDICAL EXPENSE CLAIM FORM

**Please complete, sign and return promptly to Mondial Assistance  
Without this information, we are unable to proceed with your claim.**

**P.O. Box 277  
Waterloo, ON Canada  
N2J 4A4**

**or P.O. Box 71987  
Richmond, VA USA  
23255-1987**

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Case # \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Patient's Date of Birth: \_\_\_\_\_  Male  Female Patient's Relationship to Policyholder: \_\_\_\_\_  
MM/DD/YEAR  
 Patient's Provincial Health Card Number (including version code for residents of Ontario): \_\_\_\_\_

### INSURER'S INFORMATION

Policyholder Name: \_\_\_\_\_  
 Policyholder's Date of Birth: \_\_\_\_\_ Mondial Assistance Group #: \_\_\_\_\_ Green Shield I.D. #: \_\_\_\_\_  
MM/DD/YEAR

### TRAVEL DETAILS

Was this your 1<sup>st</sup> trip outside your home province this year?  Yes  No, this was my \_\_\_\_\_ stay outside my home province this year.  
 Departure Date: \_\_\_\_\_ Anticipated/Scheduled Date of Return: \_\_\_\_\_ Actual Return Date: \_\_\_\_\_  
MM/DD/YEAR MM/DD/YEAR MM/DD/YEAR  
 Nature of Travel:  Business  Vacation  Study  Medical Care  Other: \_\_\_\_\_

### OTHER INSURANCE INFORMATION (if applicable, include spousal information for co-ordination of benefits)

<b>Employer Information</b> <b>If retired, specify name of employer providing benefits:</b> Employer Name: _____ Retired? <input type="checkbox"/> Address: _____ Phone: _____	Spouse's Name: _____ Spouse's Date of Birth: _____ <small>MM/DD/YEAR</small> Spouse's Employer: _____ Retired? <input type="checkbox"/> Address: _____ Phone: _____
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**Please indicate all other insurance coverage you have through any other insurer:** (i.e. employee/retiree/spousal group benefits, enhanced credit cards, personal property such as home/auto or any other purchased travel plan). Attach an additional page if required.

1) Name of Insurer: _____ Address: _____ Policy #: _____ Certificate #: _____	Phone: _____ Lifetime payable limit on policy? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify) \$ _____ Signature of Policyholder: _____
2) Name of Insurer: _____ Address: _____ Policy #: _____ Certificate #: _____	Phone: _____ Lifetime payable limit on policy? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify) \$ _____ Signature of Policyholder: _____

If trip purchased by **Credit Card**, specify card name: \_\_\_\_\_ Number: \_\_\_\_\_ Expiry: \_\_\_\_\_  
 Have these bills been filed with any other company?  No  Yes If yes, name and contact info: \_\_\_\_\_

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|---|--|
| <b>Additional documentation that IS REQUIRED (check if including)</b><br><input type="checkbox"/> Original, itemized medical bills and prescription receipts if received by patient<br><input type="checkbox"/> Photocopy of patient's Provincial Health Card | <b>Additional documentation that MAY BE REQUIRED</b><br><input type="checkbox"/> Accident Report (if applicable)<br><input type="checkbox"/> Completed Provincial Health claim forms (only required if you are a resident of British Columbia or Newfoundland)<br><input type="checkbox"/> Proof of Departure (envelope enclosed if required by your plan) |
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**MEDICAL INFORMATION – (Complete only if you did not contact Mondial Assistance at the time of medical emergency)**

Please describe briefly, the situation leading you to seek medical attention, including the diagnosis.

Were medical services required as result of an accident? Yes No If "Yes", please provide details and include an accident report with this form.

Name of Hospital or treating facility: \_\_\_\_\_ Date of Occurrence: \_\_\_\_\_

MM/DD/YEAR

Have you had any of these conditions before? Yes No

Date medications **last** changed **before** your departure (includes type and dosage): \_\_\_\_\_

MM/DD/YEAR

Name, Address and Phone # of your Family Physician: \_\_\_\_\_

**Last** medical visit (in Canada) before your trip? \_\_\_\_\_ Country where claim occurred: \_\_\_\_\_

MM/DD/YEAR

Have you paid for treatment? Yes No If "Yes", please specify: Partial or Paid in Full and submit proof of payment

Total amount being claimed: \$ \_\_\_\_\_ Currency: \_\_\_\_\_

**AUTHORIZATION**

**SPECIAL DIRECTION FOR GOVERNMENT HEALTH INSURANCE PLAN AND OTHER INSURANCE COVERAGE**

I direct and authorize my provincial government health insurance plan (GHIP), including OHIP, to make a payment in respect of my claim for out-of-country health services to World Access Canada, doing business as Mondial Assistance, directly and I hereby release GHIP, upon payment to World Access Canada from any further claim or cause of action in connection herewith.

I hereby consent and authorize GHIP, including OHIP, to directly or indirectly collect and use personal information including personal health information related to payment of my claim for out of country services (pursuant to Section 39 (1) of the Freedom of Information and Protection of Privacy Act, and for Ontario residents pursuant to the Health Insurance Act and the Personal Health Information Protection Act).

I consent to the disclosure by GHIP, including OHIP, to World Access Canada of such personal information including personal health information that is related to the processing and payment of my claim for out-of-country health services, including the details of any duplicate payment previously made directly to me. I understand that I may withhold my consent to the collection, use, disclosure of such information, however, if I do so my claim cannot be processed and paid. In consideration of payment made on my behalf, I authorize any benefits paid or payable by any other insurance carrier in respect to this claim, to be assigned in whole or in part to World Access Canada or, if directed by World Access Canada, to the insurance company underwriting the policy for which such payment was made.

**CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION**

I certify that I have completed this claim form and that the answers I given on Page 1 and Page 2 are complete, current and accurate to the best of my knowledge and belief.

I authorize any physician, hospital or other medical provider who has attended or examined me to release to and exchange with Mondial Assistance or its representatives any and all information regarding my medical history, symptoms, treatment, examination or diagnoses for the purpose of adjudicating my claim.

I authorize any other insurance carrier to release and exchange with Mondial Assistance or its representatives any medical or benefits payment information relating to this claim.

I understand that if I am a dependant under this plan, the policyholder will have access to information about me related to this claim in connection with administration of this plan.

I agree that a photocopy or facsimile of this authorization shall be valid as the original and that this authorization shall be considered valid for the duration of this claim, but not to exceed two years from the date it is signed. I understand information about me may be reviewed in the event that this plan is audited.

Name of Patient (Please print): \_\_\_\_\_ Date: \_\_\_\_\_

MM/DD/YEAR

Canadian Address: \_\_\_\_\_

Signature of Patient / Designated Legal Proxy \*: \_\_\_\_\_ Phone #: \_\_\_\_\_

\* If the patient is a minor, his/her legal guardian must sign on his/her behalf. If a legal representative other than the patient's legal guardian signs this form, (power of attorney, executor/executrix etc.) the provincial health plan requires proof of "Legal Representative" status.

**When sending original documents, be sure to keep a copy for your records.  
If you have questions, please call us at 1-800-363-1835. Our Customer Service Team can help.**