guard.me® CANADA
EMERGENCY MEDICAL CARD

Insured: Alfredo Manuel Rosario Morgado
Date of Birth: Mar-30-1970 Group #: 520271
Start Date: Sep-01-2016 Cert # 01433913UD
End Date: Aug-31-2017
Organization: Conestoga

sécurindemnité claimsecure

EMERGENCY PROCEDURES
Contact the 24 Hour Emergency Assistance Number:
1. Within 24 hours of admission to Hospital, or if incapacitated, as soon as reasonably possible;
2. For any benefit where prior approval is required;
3. For inbound insureds on an Excursion, prior to incurring ANY medical expenses.

Toll free North America / Numero gratuit en Amerique du Nord
1 888 756 8428

MESURES D'URGENCE
Appelez le numéro d'urgence disponible 24h/24h :
1. Dans les 24 heures ou le plus tôt possible en cas d'hospitalisation;
2. Pour tout authorisation préalable si cela s'avère nécessaire;
3. Si l'affilié est en voyage et avant qu'il n'entame des dépenses médicales.

or collect anywhere else in the world / partout ailleurs dans le monde appeler le
(905) 731 8291

Perscription Medications ONLY / Pour les médicaments d'ordonnance SEULEMENT
sécurindemnité claimsecure
For Pharmacy Inquires ONLY / Pour les pharmacies SEULEMENT
1 888 513 4464
Underwritten by Old Republic Insurance Company of Canada

PLEASE PRINT CLEARLY

guard.me Policy Number:	01433913UD	**Coverage Start Date:**	Sep-01-2016
Organization or School Name:	Conestoga	**Coverage End Date:**	Aug-31-2017
Name of Insured/Patient:	Alfredo Manuel Rosario Morgado	**Date of Birth:**	Mar-30-1970

Who do we pay: And How: ○ **Cheque (Make cheque payable to):** ○ **Electronic Payment (Attach VOID cheque)**

Name _____

Address _____

Tel: _____ **Fax:** _____ **Email:** _____

1. **Do you have any other insurance?** You must answer ○ **NO** or ○ **YES** (Include ANY other insurance.) If YES, provide details:

2. **Were you hurt in an accident?** ○ **NO** or ○ **YES** Tell us what happened, including when and where the accident happened:

3. **Tell us WHEN and WHY you saw the doctor (below).** Original bills and receipts must be sent with this Claim Form for us to pay you.

Date (d/m/y)	Cost/Currency	Why you needed medical care (Diagnosis)

FOR DIRECT BILLING BY MEDICAL PROVIDERS ONLY

For prompt reimbursement as detailed below, FAX this signed form to guard.me

○ **Rx given** ○ **X-ray Ordered** ○ **Lab work Ordered** ○ **Other/Details**

A) Is this emergency treatment, medically necessary to identify and/or treat an acute, unexpected sickness? ○ **NO** *or* ○ **YES**

OR B) Is this treatment pre-arranged and/or given to maintain the stability of a chronic sickness or condition? ○ **NO** *or* ○ **YES**

AND C) Did the same or similar conditions occur in the 90 days prior to the Coverage Start Date? ○ **NO** *or* ○ **YES**

If YES, provide details and dates: _____

If you answer YES to A) we will reimburse you directly.

If you answer YES to B) or C), have the insured pay for this visit. Questions? Please call the number below.

Medical Provider's Name **PRINT** _____ Date _____ Medical Provider's Signature **(only required for direct payment)**

ATTACH ALL BILLS and MAIL TO:
guard.me Claims
300 John Street, Suite 405
Thornhill (Ontario) Canada L3T 5W4
TEL: 1 888 756 8428
www.guard.me
Medical Providers only Fax to:
1 866 329 6948 *or* 905 731 6948

I, the undersigned, declare that all the information I have provided in this Claim Form is true and complete. I acknowledge receipt of ***Travel Healthcare Insurance Solutions Inc. /guard.me***'s privacy statement. I authorize any hospital, physician, other medical provider or insurer to provide by any means my complete medical record to ***Travel Healthcare Insurance Solutions Inc. /guard.me*** and its insurers for the purpose of administering claims. All information is to be held in complete confidentiality and is not to be released to any party apart from those listed above. Use of my email address will be restricted to insurance inquiries unless I initiate email contact. A photocopy or facsimile transmission of this Claim Form is as valid as the original. I assign my right to payment to the party indicated above.

_____ _____
Signature (Claimant) Date