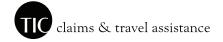
HOW TO SUBMIT A CLAIM – VISITORS TO CANADA



IMPORTANT

- All claims must be reported within 30 days of occurrence.
- Written proof of claim must be submitted within 90 days of occurrence.
- You are responsible for any fees charged for completing this form or issuing supporting documentation.

TO SUBMIT YOUR CLAIM:

- STEP 1 Gather all your claim documentation
- STEP 2 Complete and sign the claim form
- STEP 3 Complete the checklist below
- STEP 4 Mail all documentation to TIC

CHECKLIST

Do you have:

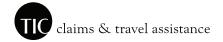
The fully completed claim form, signed and dated? ☐ Sections 1, 2, 3, 4, & 6 (completed by you) ☐ Section 5 (completed by your attending physician/dentist) Incomplete claim forms will be returned to you and this will delay the processing of your claim submission.
Emergency room report and/or hospital records (if treated at a hospital/outpatient facility)?
All original receipts? Photocopies will not be accepted.
A copy of all documents for your records?

Send your completed forms and original receipts to:

TIC Claims Department 2100 – 250 Yonge Street Toronto, Ontario M5B 2L7 To check your claim status, please call:

Toll-free Canada/USA: 1-800-869-6747 Collect worldwide: 416-340-8809 E-mail: <u>claims@travelinsurance.ca</u>

CLAIM FORM – VISITORS TO CANADA



SECTION 1: PRIVACY AND DECLARATION

TIC Travel Insurance Coordinators Privacy Statement

TIC is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

At TIC, we recognize and respect the importance of privacy. When you enrol for insurance coverage or submit a claim, we establish a confidential file and collect, use and disclose your personal information for the purposes of issuing, administering, adjudicating and/or servicing your insurance. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other persons we have authorized who have a need to know it to perform their duties. Our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security extends to the contracts and agreements we sign with external suppliers and service providers. We may store or process your personal information in Canada, the United States or other countries for processing, storage, analysis or disaster recovery and, under applicable law, governments, courts, law enforcement or regulatory agencies, may, by lawful order, obtain disclosure of your personal information. You can find more details about TIC's privacy policy at www.travelinsurance.ca. If you have any questions regarding our privacy practices, please contact the Privacy Officer at:

TIC Travel Insurance Coordinators Ltd 2100 – 250 Yonge Street, Toronto, ON M5B 2L7

Telephone: 416-340-0100 E-Mail: privacy@travelinsurance.ca

If you do not agree with our use and disclosure of your information in connection with your application and servicing any policy that we issue, we will not be able to offer you the insurance product you are interested in, service your insurance or adjudicate your claim.

I have read and understood the privacy statement and I consent to the collection, use, retention and disclosure of my personal information or those of my dependants for the purposes stated above. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated.

I hereby assign to TIC any benefits obtainable from other sources for losses covered under this policy. I authorize and direct these sources to release payments to TIC and for TIC to release pertinent payments to other parties for the purposes of processing my claim.

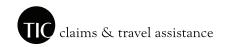
I certify that the information contained herein is true, complete and accurate and that each of the listed expenses was purchased and/or incurred in connection with the medical treatment of the individual(s) named below. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning this claim, I acknowledge and agree that TIC may investigate any information about me, my spouse and/or dependents pertaining to this claim, which may be used and disclosed to any relevant Third Party, and where applicable my plan sponsor, for the purpose of investigating and preventing fraud and/or plan abuse.

If I receive payment from TIC in an amount that exceeds the benefit(s) to which I am entitled under the policy (the "overpayment amount"), then I acknowledge and agree that: (a) I am indebted to TIC for such overpayment; (b) TIC has the right to recover the overpayment amount through any means available by law; and (c) TIC will offset any benefits payable to me by the overpayment amount until TIC has recovered the overpayment amount in full.

I declare my statements above, including all other past and future statements made through personal or telephone interviews relating to my claim, to be true, complete, current and accurate.

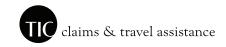
Insured's Signature:	Date:	MM/DD/YYYY
Insured's Name (please print):	Policy #:	

CLAIM FORM – VISITORS TO CANADA



SECTION 2: INSURED'S INFORMATION			
Insured's First Name:	Last Name:		
☐ Male ☐ Female ☐ Date of Birth: MM/DD/YYYY	Policy #:		
Address in Canada			
Street Address:			
City:	Province:	Postal Code:	
Telephone: ()	Email:		
Country of Origin:	Date of Arrival in Canada:	MM/DD/YYYY	
Name and Address of Family Physician in Country of Origin:			
First Name:	Last Name:		
Street Address:			
City/Town:	Postal Code:	Telephone: ()	
Name and Address of Family Physician in Canada:			
First Name:	Last Name:		
Street Address:			
City/Town:	Postal Code:	Telephone: ()	
Do you have other insurance coverage including Canadian government health insura	nce?		
Do you have insurance coverage through your spouse? ☐ Yes ☐ No			
If 'Yes', please provide name and address of other insurance company/coverage:			
Name:			
Street Address:			
City/Town:	Postal Code:	Telephone: ()	
SECTION 3: MEDICAL INFORMATION			
Brief description of sickness or injury:			
Date symptoms or injury first appeared: MM/DD/YYYY Dat	e you first saw physician for thi	s condition: MM/D	D/YYYY
In the case of an injury, how, when and where did it happen?			
	□ No		
If 'Yes', give all dates of treatment and list all medication taken BEFORE the effective			
Date: MM/DD/YYYY Medication:	date of the current policy.		
Date: MM/DD/YYYY Medication:			
medication.			
SECTION 4: EXPENSES CLAIMED			
Name of Provider Diagnosis	Date of Service	Amount Billed	Amount Paid
1.	MM/DD/Y		Amount raid
	, , ,		
2.	MM/DD/YY	TT	
SECTION 5: ATTENDING PHYSICIAN/DENTIST STATEMENT			
Name of Patient:		ate of Birth:	M/DD/YYYY
			M/DD/YYYY
Diagnosis Claimed For: When did symptoms for this condition, or injury first occur? M.M./D.D./Y.		ate of First Consultation:	., ,
i. When did symptoms for this condition, or injury first occur.			
2. Has the claimant/patient ever had the same or similar condition during the 12 m	ontns prior to this visit?	☐ Yes ☐ No	
If 'Yes', please advise:			
D (() C II II II II II M M / D D / V V V V M M / D D			/nn/vvvv
Date(s) of all medical visits: MM/DD/YYYYY MM/DD Diagnosis:	Treatment Rend		/DD/YYYY

CLAIM FORM – VISITORS TO CANADA



SE	ECTION 5: ATTENDING PHYSICIAN/DENTIST STATEMENT (CON'T)		
3.	. Was the claimant/patient referred to you?		
٦٠	If 'Yes', please provide the name/address of referring physician:		
,		Yes	□ No
4.	If 'Yes', please provide the name/address of this physician:	103	- NO
	ii 163, piedase provide the name/address of this physician.		
_	Describe any other diseases or infirmity affecting the condition being claimed:		
5.	bescribe any other diseases of minimity anceting the condition being claimed.		
4	List all medication(s) claimant/patient was taking at the time of initial consultation:		
6.	List all medication(s) claimant/patient was taking at the time of initial consultation.		
7	. Was the claimant/patient hospitalized?		
7.	Date of Admission: M.M./D.D./YYYY Date of Discharge: M.M./D.D./YYYY		
8.	bute of Marinasion.		
0.	If 'Yes', please provide name and address of surgeon and hospital:		
	ii 163 , piedase provide name and address or surgeon and nospital.		
9.	. Was this condition due to pregnancy?		
7.	If 'Yes', date of last menstrual period MM/DD/YYYYY and expected date of delivery: MM/DD/YYYYY		
10	b. Was this condition due to the use of alcohol, misuse of drugs, or self-inflicted injury?		
10.	If 'Yes', please give details:		
11.	MM/DD/VVVV		
	2. In your opinion, could treatment for the condition have been postponed until the patient's return to their country of origin?	Voc [□ No
12.	If 'No', please provide details, and date the insured would be medically certified as fit to travel:	165	■ NO
	ii No, please provide details, and date the histied would be medically certified as it to travel.		
	20.00	DD/	YYYY
DI.	Date fit to Travel: M M /	DD/	YYYY
	Date fit to Travel: M.M./ hysician's certification and signature	DD/	YYYY
	Date fit to Travel: M.M./ hysician's certification and signature certify that the information provided in this section is complete, true and accurate to the best of my knowledge and belief.		YYYY
l ce	Date fit to Travel: MM/ hysician's certification and signature certify that the information provided in this section is complete, true and accurate to the best of my knowledge and belief. PHYSICIAN'S STAMP HER hysician's Signature:		YYYY
l ce	Date fit to Travel: M.M./ hysician's certification and signature certify that the information provided in this section is complete, true and accurate to the best of my knowledge and belief. PHYSICIAN'S STAMP HER		YYYY
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Phy Dat Str. City Tele	hysician's certification and signature certify that the information provided in this section is complete, true and accurate to the best of my knowledge and belief. hysician's Signature: hysician's Name (please print): ate: treet Address: Email: Ema	reinsu me, m d all su	y spouse ch
Phy Date Str. City Teld	hysician's certification and signature certify that the information provided in this section is complete, true and accurate to the best of my knowledge and belief. hysician's Signature: hysician's Name (please print): ate: MM/DD/YYYY	reinsu me, m d all su y of my	y spouse ch y claim,
Phy Date Str. City Tel. By pro and infearor share shar	hysician's certification and signature certify that the information provided in this section is complete, true and accurate to the best of my knowledge and belief. hysician's Signature: hysician's Name (please print): ate: Email: treet Address: Email:	reinsu me, m d all su y of my provide	y spouse ch y claim, d herein
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