SECTION A: CLAIMANT INFORMATION

Insured's First Name: Xiuxue Last Name: Tao

☐ Male ☒ Female Date of Birth: 01/09/1940 Policy #: OPT 125957

Address in Canada

Street Address: 230 Maxwell Bridge Rd

City/Town: Kanata, ON **Postal Code:** K2W 0B7

Telephone: (613) 271-8099 Email: daizhuzhao@gmail.com

Country of Origin: China Date of Arrival in Canada: 04/29/2012

Name and Address of Family Physician in Country of Origin Name:

Street Address:

City/Town: **Postal Code:** **Telephone:** ( )

Name and Address of Family Physician in Canada Name:

Street Address:

City/Town: **Postal Code:** **Telephone:** ( )

Do you have other insurance coverage including Canadian government health insurance? ☐ Yes ☒ No

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 B: MEDICAL INFORMATION

Brief description of sickness or injury: Sudden Onset of shoulder pain

Date symptoms or injury first appeared: 08/21/2012 Date you first saw physician for this condition: 08/22/2012

Have you ever been treated for this or a similar condition before? ☐ Yes ☒ No

If 'Yes', give all dates of treatment and list all medication taken **BEFORE** the effective date of the current policy:

Date: MM/DD/YYYY Medication:

Date: MM/DD/YYYY Medication:

SECTION C: EXPENSES CLAIMED

Name of Provider	Diagnosis	Date of Service (MM/DD/YYYY)	Amount Billed	Amount Paid
1. MCBRIDE, MICHELLE-FHO	Shoulder pain	08/22/2012	$40.	$40
2. Gamma-Dynacare	Blood test	08/22/2012	$126.67	$126.67
3. Gamma-Dynacare	Blood test	08/22/2012	$23.70	$23.70

SECTION D: AUTHORIZATION AND CERTIFICATION

TIC is committed to protecting the privacy, confidentiality and security of the personal information we collect, use and disclose. Your personal information will be used only for the purpose of providing you with the requested insurance services. For a copy of TIC's privacy policy, please contact us.

I authorize any doctor, hospital or facility providing medical or health related services, and any other insurer to release and exchange with TIC or its representatives, any information that is required to process this claim. I assign to TIC any benefits payable from any other sources for losses covered under this policy, and I authorize and direct such payors to forward payment directly to TIC. I also authorize any third party providing me with assistance in this claims process, to have access to any and all relevant claims information related to the adjudication of my claim with TIC. I confirm I am authorized to act on behalf of my dependants for these purposes. A photocopy of this authorization shall be as valid as the original. I certify that the information provided in connection with this claim is complete, true and accurate.

Full Name of Patient/Insured (please print): Xiuxue Tao Date: 11/07/2012

I authorize payment of this claim to (print name): Daizhu Zhao

Signature of Insured (if minor, signature of parent or legal guardian): PX

Signature of policy holder of other insurance in Section A (if applicable):

TIC claims & travel assistance

Privacy Release Form - Third Party

I, Tao, xiuxue (INSURED PERSON), give permission for _____ (THIRD PARTY) to have access to any and all relevant claims information, including medical records, related to the adjudication of my claim #_____ (CLAIM NUMBER) with TIC Travel Insurance Coordinators Ltd. (TIC).

I understand that this information will be shared between TIC and the third party named above solely for the purpose of this person assisting me in understanding the claim adjudication and its results.

Signed this 07 (DAY) day of 11 (MONTH), 20 12 (YEAR).

PX
SIGNATURE OF INSURED PERSON

Xiuxue Tao
NAME OF INSURED PERSON (PLEASE PRINT)

TIC claims & travel assistance

TIC Travel Insurance Coordinators
Eastern Claims Toll free 1 800 869 6747
Eastern Claims Fax + 416 340 7152

Privacy Release Form - Third Party

I, _____ (INSURED PERSON), give permission for _____ (THIRD PARTY) to have access to any and all relevant claims information, including medical records, related to the adjudication of my claim #_____ (CLAIM NUMBER) with TIC Travel Insurance Coordinators Ltd. (TIC).

I understand that this information will be shared between TIC and the third party named above solely for the purpose of this person assisting me in understanding the claim adjudication and its results.

Signed this _____ (DAY) day of _____ (MONTH), 20_____ (YEAR).

PX
SIGNATURE OF INSURED PERSON

Xiuxue Tao
NAME OF INSURED PERSON (PLEASE PRINT)

TIC claims & travel assistance

TIC Travel Insurance Coordinators
Eastern Claims Toll free 1 800 869 6747
Eastern Claims Fax + 416 340 7152

5T004MF-0508

Medical Procedure - Appointment Requisition

Office: MCBRIDE, MICHELLE-FHO
2-832 MARCH RD
KANATA, ON K2W 0C9

Tel: 613-599-5599
Fax: 613-599-1005

Patient: TAO, XIUXUE
230 MAXWELL BRIDGE RD
KANATA, ON K2W 0B7

Tel: 613-271-8099 File #: 3639051
DOB: 09-Jan-1940 Age: 72 yr
Health #: Sex: F

Location: CML Kanata Entered by: DRMM Entry date: 22-Aug-2012
Tel: 613-592-0711 Fax: 613-592-1412

Requester: MCBRIDE, MICHELLE-FHO Procedure #: 23690 Importance: Normal

Procedure: Shoulder (XR) Specific:

Other Proc:

Date: Time: Admission Date:

Diagnosis:

Anaesthetic:

Est. Procedure Time:

Provider: Department:

Assistant: Case Type:

Anesthesiologist: Est. Stay 0 days

Family Dr: Prev. Admission:

Notes: Sudden onset of shoulder pain. Features possibly suggestive of inflammatory arthritis.

CC:

MCBRIDE, MICHELLE-FHO
2-832 MARCH RD
KANATA, ON K2W 0C9
Tel: 613-599-5599
Fax: 613-599-1005

Receipt for Professional Services

MCBRIDE, MICHELLE-FHO

Receipt To: XIUXUE TAO
230 MAXWELL BRIDGE RD
KANATA, ON K2W 0B7

Patient: XIUXUE TAO
230 MAXWELL BRIDGE RD
KANATA, ON K2W 0B7

Born: January 9, 1940

Date: August 22, 2012

SIN:

File #: 3639051

Service Details:

* = GST ** = GST & PST # = HST

Date	Description	Qty	Charges	Taxes	Payments	Balance	Acct #
Aug 22/12	uninsured p/e	1	$40.00		$40.00		89281

GST:	$0.00
PST:	$0.00
HST:	$0.00
Total Payments:	$40.00
Balance:	$0.00

Notes:

Gamma-Dynacare
Medical Laboratories

2012/08/22 14:43:56

Receipt

Invoice : **4479086**
Requisition # : 51219498
Specimen Coll Site : XQ, 99 KAKULU

TAO, XIUXUE
230 MAXWELL BRIDGE RD
Kanata
Ontario Canada K2W 0B7

Referring Doctor: MICHELLE ANN MCBRIDE
Service Date: 2012/08/22 14:43:46
Patient phone no: 613-271-8099

Code #	Description	Comments	Unit Price	No. Services	Billed
HLAB	HLA B27 ADDITIONAL BILLING		$7.76	1	$7.76
685H	HLA B27		$103.40	1	$103.40
500R	RA LATEX		$3.10	1	$3.10
451	E.S.R.		$1.55	1	$1.55
665	CRP		$3.10	1	$3.10
700	DOCUMENTATION FEE		$7.76	1	$7.76

Total Invoice: $126.67

Payments:

Mastercard $126.67

$126.67

Balance Owing: $0.00

This invoice is a billing for laboratory services that are not covered by your Provincial Insurance Plan.
Payment for these services is the responsibility of the patient

Please note additional tests may be required to complete testing, additional cost may apply.

Please note your invoice number on your cheque or money order and forward payment.
ATTENTION: BILLING at GAMMA-DYNACARE LABORATORIES:

115 Midair Court, Brampton, Ontario, L6T 5M3 1-866-790-5448 OR 1-905-790-5448

THANK YOU,
GAMMA-DYNACARE MEDICAL LABORATORIES

Printed Date 2012/08/22 14:43:56

INVOICE

Laboratoires Médicaux
Gamma-Dynacare
Medical Laboratories
115 Midair Court, Brampton, Ontario L6T 5M3
TEL: (905) 790-5448
SANS FRAIS / TOLL FREE 1-866-790-5448 FAX: (905) 790-3055
gamma-dynacare.com

DATE DE FACTURE / INVOICE DATE: 2012-08-27
DATE DE SERVICE / SERVICE DATE: 2012-08-22
NUMÉRO DE FACTURE / INVOICE NO: XQ 51219498
CASE / SLOT: L1
CODE D'EMPLACEMENT / LOCT CODE: XQ

COMPTE / IN ACCOUNT WITH:
TAO, XIUXUE
230 MAXWELL BRIDGE RD
KANATA
ONTARIO
K2W 0B7

NUMÉRO DE CLIENT / CLIENT NO.: 019533

MÉDECIN REQUÉRANT / REFERRING PHYSICIAN:
M.A. MCBRIDE
KANATA NORTH MEDICAL CENT
2-832 MARCH RD
KANATA, ON
K2W 0C9

Test Code			SVS	Test Description	Amount
HLAB	L686A	*	1	HLA B27 ADDITIONAL BILLING	7.76
451	L451A	*	1	E.S.R.	1.55
500R	L500A	*	1	RHEUMATOID FACTOR	3.10
665	L665A	*	1	CRP	3.10
685H	L685A	*	1	HLA B27	103.40
700	L700A	*	1	DOCUMENTATION FEE	7.76
82FR	L846A	*	2	CONSULTANT FEE (DR.FERNANDES)	23.70

Invoice Amount	150.37	
Payment Amount	126.67	MST
Amount Due	23.70	

* We were unable to submit this claim to your government plan because the information provided did not match records at the Ministry or Department of Health in your province. Please verify that your health card, version code and date of birth appear correctly on the invoice. If there is an error, contact our office at 1-866-790-5448 to update our records.

---PAYMENT OPTIONS---

How to pay your GAMMA-DYNACARE invoice:

- Online at gamma-dynacare.com
- Pay at a Gamma-Dynacare Patient Services Centre
- Credit card payments over the phone
- By Mail at 115 Midair Court, Brampton,ON L6T 5M3
- Pay at most major banks, trust company or credit unions using bank machine, telephone or online banking. Use Gamma Dynacare Medical Laboratories as your payee and your invoice number as the account number

27616-001
BMO Bank of Montreal
SEP 26 2012
110 Place D'Orleans Dr.
Ottawa, Ontario
28 27616-001

AMT/TYPE: 126.67 cc

S'IL VOUS PLAÎT CONSERVER POUR VOS DOSSIERS / PLEASE RETAIN FOR YOUR RECORDS

VEUILLEZ DÉTACHER CETTE PARTIE ET RETOURNEZ AVEC VOTRE PAIEMENT / PLEASE DETACH THIS PORTION AND RETURN WITH YOUR REMITTANCE

S'IL VOUS PLAÎT ENVOYER À / PLEASE REMIT TO: GAMMA-DYNACARE MEDICAL LABORATORIES
115 MIDAIR COURT, BRAMPTON, ONTARIO, L6T 5M3

MÉTHODE DE PAIEMENT / METHOD OF PAYMENT: ☐ VISA ☐ MASTERCARD ☐ CHÈQUE PAYABLE À: GAMMA-DYNACARE MEDICAL LABORATORIES

CARTE DE CRÉDIT / CREDIT CARD #: _____ DATE D'ÉCHÉANCE / EXPIRY DATE: _____ mois / année month / year

NOM DE DÉTENTEUR DE CARTE / CARDHOLDER NAME: _____

SIGNATURE / SIGNATURE: _____

DATE DE FACTURE / INVOICE DATE: 2012-08-27
NUMÉRO DE FACTURE / INVOICE NO.: XQ 51219498
NUMÉRO DE CLIENT / CLIENT NO.:
NOM / NAME: TAO XIUXUE
NUMÉRO DE CARTE SANTÉ / HEALTHCARD NO./ VERSION CODE: 0000000001
DATE DE NAISSANCE / DATE OF BIRTH: 1940-01-09
SOLDE DÛ / BALANCE DUE: 23.70

FORM-INVO-DIREC 12/10