VISITORS TO CANADA EMERGENCY HOSPITAL & MEDICAL INSURANCE CLAIM FORM

To make a claim, complete this form and forward to:

TIC Claims Department
250 Yonge Street, Suite 2100
Toronto, ON, M5B 2L7
Collect worldwide: 416-340-1980
Toll free Canada/U.S.A.: 1-800-670-4426

Johnson Fu Insurance Agency Inc.
www.jfiginsgroup.com

INSTRUCTIONS

IMPORTANT

- In the event of hospitalization, TIC Travel Insurance Coordinators Ltd. (TIC) must be notified prior to, or within 24 hours of admission to hospital and prior to any surgery or invasive investigations being performed.
- 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.

REQUIREMENTS

- Fully completed and signed Claim Form, sections A, B, C & D.
- Completed Attending Physician/Dentist Statement, Section E. (Only applies to Hospital Emergency & Hospitalization)
- Emergency room report and/or hospital records if treated at a hospital/outpatient facility.
- All original bills and/or receipts. Photocopies will not be accepted.
- All bills must be itemized and show dates and costs of all treatment received.

SECTION A: CLAIMANT INFORMATION

Insured's First Name: Lihua Last Name: Huang

☐ Male ☒ Female Date of Birth: 12 24 1941 Policy #: OPT128662

Address in Canada

Street Address: 4136 Sophia Street

City/Town: Vancouver Postal Code: V5V 3V5

Telephone: (778) 883-3799 Email: adelawong@yahoo.com

Country of Origin: China Date of Arrival in Canada: 06 06 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: Wai-Arm Lam

Street Address: 207 - 236 E. Georgia St.

City/Town: Vancouver Postal Code: V6A 1Z7 Telephone: (604) 688-6415

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:

Earache

Date symptoms or injury first appeared: 06 10 2012 Date you first saw physician for this condition: 06 14 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: Medication:

Date: Medication:

Date: Medication:

SECTION C: EXPENSES CLAIMED

Name of Provider	Diagnosis	Date of Service (MM/DD/YYYY)	Amount Billed	Amount Paid
1. Dr. Wai-Arm Lam Corporation	Earache	06 14 2012		$80.-
2. Corning Drugs Ltd. #2	Earache	06 14 2012		$36.61
3.				
4.				

SECTION D: AUTHORIZATION AND CERTIFICATION (CONTINUED ON NEXT PAGE)

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.

CONSENT TO RELEASE OF INFORMATION

I Lihua Huang hereby authorize **Johnson Fu Insurance Agency Inc.** to act on my behalf all information and documentation, including medical and other personal information, provided by me or obtained by **Johnson Fu Insurance Agency Inc.** from third parties (collectively, " records") regarding any matter for which I may make a claim to **Johnson Fu Insurance Agency Inc.** under a policy of insurance. I understand that the purpose for the provision of records to and the discussion of records is to enable **Johnson Fu Insurance Agency Inc.** and insurers to determine whether and to what extent my claim may be covered by insurance and to facilitate communications about my claim. This authorization takes effect on the date set out below and may be revoked by me at any time in writing. If this authorization is revoked before the provision of records to and the discussion of records, the assessment and processing of my claim may be delayed.

A copy of this authorization received by **Johnson Fu Insurance Agency Inc.** shall be as effective and valid as the original.

Date: 25/06/2012 (dd/mm/yy) Insured's name: Lihua Huang (Please Print)

Signed: Lihua Huang (Insured or authorized representative) _____ (Print name of authorized representative)

_____ (Relationship to Insured)

Please indicate to whom payment should be made: Liping Huang

SECTION D: AUTHORIZATION AND CERTIFICATION (CONTINUED FROM PREVIOUS PAGE)

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): Lihua Huang Date: 06 25 2012

I authorize payment of this claim to (print name): Liping Huang

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

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

Dr. Wai-Arm Lam Corporation.
#207-236 East Georgia Street,
Vancouver, BC, V6A1Z7
Phone (604) 688-6415

No. 12-017

RECEIVED FROM / REÇU DE Huang Li Hua

JUN 14 2012 20

$ 80.✓

The Sum of / la somme de Eighty Dollars

for. offic visit " earache "

ey

If 'Yes', please provid

CORNING DRUGS LTD. #2 C77
康寧藥房 236 E. GEORGIA ST. VANCOUVER, B.C. V6A 1Z7 **685-7609**

Receipt - PATIENT PAY $36.61
9758109271 Dr:WAI-ARM LAM 91
HUANG,LI HUA
C77 Rx516199 Dr10052 14JUN12
7.5 CIPRODEX EAR DROPS DIN2252716
PNET=0.00 Qty_re=0
C29.22+F7.39=36.61

516199 14JUN12 $ 36.61 EL Dr:6886415
4136 SOPHIA ST 7.5 2252716

5. Describe any other di

6. List all medication(s)

7. Was the claimant/pat

Date of Admission:

8. Was any surgery perf
If 'Yes', please provid

9. Was this condition du pre
If 'Yes', date of last m

10. Was this condition due to the use of alcohol, misuse of drugs, or self-inflicted injury? ❑ Yes ❑ No
If 'Yes', please give details:

11. Was this condition due to a motor vehicle accident? ❑ Yes ❑ No If 'Yes', date of accident/injury:

12. In your opinion, could treatment for the condition have been postponed until the patient's return to country of origin? ❑ Yes ❑ No
If 'No', please provide details, and date the insured would be medically certified as fit to travel:

Date fit to Travel:

PHYSICIAN'S CERTIFICATION AND SIGNATURE
I certify that the information provided in this section is complete, true and accurate to the best of my knowledge and belief.

Physician's Signature:

Physician's Name (please print):

Date: Email:

Street Address:

City/Town: Postal Code:

Telephone: ( ) Fax: ( )

PHYSICIAN'S STAMP HERE

TIC claims & travel assistance