



Re: Out of Country Medical Expenses Claim

We are sorry that you ran into this unfortunate situation on your trip. In your original travel insurance package, you will note that Active Care Management is the company responsible for managing your claim. In order for us to process your claim as quickly as possible, please follow the instructions below.

IMPORTANT: Within the NEXT 15 DAYS please:

- Complete all forms included with this package,
- Include ALL documents, invoices, etc. related to your claim,
- Sign the form – if you are under 18 your legal guardian must sign it,
- Return this information in the mail

If you have any questions about your claim, please contact us at 1 877-292-0082.

Sincerely,
Active Care Management

Encls

EMERGENCY HOSPITAL & MEDICAL INSURANCE FOR CANADIANS CLAIM FORM

SECTION A – CLAIMANT INFORMATION			
Insured's Name (Last Name, First Name, Middle Initial)			Date of Birth <small>MM DD YYYY</small>
Policy Number			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address	City	Province	Postal Code
Email Address		Phone ()	Fax ()
Travel Destination		Departure Date <small>MM DD YYYY</small>	Return Date <small>MM DD YYYY</small>

SECTION B – MEDICAL INFORMATION – Please List Name and Telephone Number of ALL Physicians & Specialists you were treated by prior to departure date.			
Name & Specialty			Phone ()
Name & Specialty			Phone ()
Name & Specialty			Phone ()
Name & Specialty			Phone ()
Was this condition related to a Pregnancy? <input type="checkbox"/> No <input type="checkbox"/> Yes, If Yes, Expected Date of Delivery <small>MM DD YYYY</small>			
Injury			
Is this claim the result of an Injury? <input type="checkbox"/> No <input type="checkbox"/> Yes			Date of Injury <small>MM DD YYYY</small>
Brief Description of Injury and Diagnosis			
Does this claim relate to a Motor Vehicle Accident? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Name of Motor Vehicle Insurance Company		Policy #	Phone ()
Address		City	Province Postal Code
Sickness			
Date Symptoms first appeared <small>MM DD YYYY</small>	First date of Treatment <small>MM DD YYYY</small>	Diagnosis	
Treating Doctor's Name			Phone ()
List names of any Medications you were taking prior to visiting the Doctor:			
Have you ever experienced this sickness or a similar problem before? <input type="checkbox"/> No <input type="checkbox"/> Yes			Date of Previous Occurrence <small>MM DD YYYY</small>
Do you have any Chronic Sickness or Disease? <input type="checkbox"/> No <input type="checkbox"/> Yes			Date Diagnosed <small>MM DD YYYY</small>
Describe Conditions / Diagnosis:			

EMERGENCY HOSPITAL & MEDICAL INSURANCE FOR CANADIANS CLAIM FORM (CONT'D)

SECTION C – OTHER INSURANCE COVERAGE

Do You and/or Your Spouse or Child Have Other Emergency Medical Insurance Benefits? (Check all that apply)

Employer Retiree Plan Home/Auto Other I do not have any other out of province medical insurance coverage.

Plan	Name of Insurance Company	Group Policy #	Member ID #	Phone #
Your Employer				
Your Spouse's Employer				

Name of Spouse (last name, first name):

Retiree Plan				
Other Coverage				

Signature of Policyholder of other coverage	Date of Birth MM DD YYYY
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Do you have credit card insurance coverage for out-of-Province travel? No Yes, If yes, provide:

Name of Issuing Bank for Credit Card:

Name of Cardholder	Credit Card #	Date of Expiry MM DD YYYY
Signature of Cardholder (if different from insured)		Date Signed MM DD YYYY

SECTION D – CERTIFICATION & AUTHORIZATION

The insurer, its agents and administrators are obliged to collect and retain certain personal and/or health information about you in connection with your insurance coverage. They use and disclose that information only for the purposes of administering your policy/policies of insurance, providing customer service and assessing and paying claims.

I/We authorize any licensed physician, medical practitioner, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, provincial health insurance plan and employer(s) to provide Active Care Management (ACM), and its representatives employed to assist in the administration of this claim, any information, including personal information, data or records that are in their possession/knowledge regarding my medical history and treatment.

I/We direct and authorize my Government Health Insurance Plan (GHIP) to make payment in respect of my claim for out of country Health services to ACM, directly and I hereby release GHIP, upon payment to ACM from any further claim or cause of action in connection herewith.

I hereby consent and authorize GHIP to directly or indirectly collect information contained in the claim and source documents pursuant to the freedom of information and protection of privacy act, and the Health Insurance Act.

I/We authorize ACM to coordinate the payment of benefits with any other insurance carriers which may also have a liability for this claim. I/We hereby irrevocably direct ACM to make any payments, receive payments and settle with other carriers on my/our behalf.

I hereby consent to the use of ACM, the insurers its agents and administrators of the personal and health information about me disclosed herein and in all documents or information provided in connection with my policy/policies of insurance for purposes cited above.

A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from date signed.

Name of Patient/Insured (Last Name, First Name, Middle Initial)	Date MM DD YYYY
If you authorize payment of this claim to anyone other than yourself or your provider, please provide name of recipient:	Date MM DD YYYY
Insured's Signature (If minor, signature of parent or legal guardian)	Date MM DD YYYY
Signature of policy holder of other insurance stated in Section C	Date MM DD YYYY

ACM 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 ACM's privacy policy, please contact us.