

# VISITORS TO CANADA EMERGENCY HOSPITAL & MEDICAL INSURANCE CLAIM FORM

**TIC Claims Department**  
2100 – 250 Yonge Street  
Toronto, Ontario, Canada M5B 2L7  
Collect worldwide: 416-340-8809  
Toll free Canada/U.S.A.: 1-800-869-6747

## 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.
- 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: \_\_\_\_\_ Last Name: \_\_\_\_\_

Male  Female Date of Birth: **MM/DD/YYYY** Policy #: \_\_\_\_\_

### Address in Canada

Street Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ 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

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: \_\_\_\_\_

Date symptoms or injury first appeared: **MM/DD/YYYY** Date you first saw physician for this condition: **MM/DD/YYYY**

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: \_\_\_\_\_

Date: **MM/DD/YYYY** Medication: \_\_\_\_\_

## SECTION C: EXPENSES CLAIMED

Name of Provider	Diagnosis	Date of Service (MM/DD/YYYY)	Amount Billed	Amount Paid
1.		<b>MM/DD/YYYY</b>		
2.		<b>MM/DD/YYYY</b>		
3.		<b>MM/DD/YYYY</b>		
4.		<b>MM/DD/YYYY</b>		

## 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.

**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): \_\_\_\_\_ Date: **MM/DD/YYYY**

I authorize payment of this claim to (print name): \_\_\_\_\_

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

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

**SECTION E: ATTENDING PHYSICIAN/DENTIST STATEMENT**

Name of Patient: \_\_\_\_\_ Date of Birth: **MM/DD/YYYY**

Diagnosis Claimed For: \_\_\_\_\_ Date of First Consultation: **MM/DD/YYYY**

1. When did symptoms for this condition, or injury first occur? **MM/DD/YYYY**

2. Has the claimant/patient ever had the same or similar condition during the 12 months prior to this visit?  Yes  No  
If 'Yes', please advise:

Date(s) of all medical visits: **MM/DD/YYYY** **MM/DD/YYYY** **MM/DD/YYYY** **MM/DD/YYYY**

Diagnosis: \_\_\_\_\_

Treatment Rendered: \_\_\_\_\_

3. Was the claimant/patient referred to you?  Yes  No  
If 'Yes', please provide the name/address of referring physician:

4. Are you aware of any other physician in Canada who may have treated this claimant/patient for this or a similar condition?  Yes  No  
If 'Yes', please provide the name/address of this physician:

5. Describe any other diseases or infirmity affecting the condition being claimed for:

6. List all medication(s) claimant/patient was taking at the time of initial consultation:

7. Was the claimant/patient hospitalized?  Yes  No If 'Yes', name of hospital: \_\_\_\_\_  
Date of Admission: **MM/DD/YYYY** Date of Discharge: **MM/DD/YYYY**

8. Was any surgery performed?  Yes  No  
If 'Yes', please provide name and address of surgeon/hospital:

9. Was this condition due to pregnancy?  Yes  No  
If 'Yes', date of last menstrual period **MM/DD/YYYY** and expected date of delivery: **MM/DD/YYYY**

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: **MM/DD/YYYY**

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: **MM/DD/YYYY**

**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: **MM/DD/YYYY** Email: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

