Manulife

VISITORS TO CANADA CLAIM FORM

Policy No.:
Case No.:
Form No.: MLVTC102018E

HOW TO COMPLETE YOUR CLAIM FORM

Please complete all sections of the claim form. Failure to complete the claim form and attach the requested documents will delay the processing of your claim. Below you will find clarification for the sections of the claim form which are often missed or incomplete.

SECTION B - CERTIFICATION & AUTHORIZATION

This section must be completed in order to release payment of your claim. Completion certifies that the information provided in connection with this claim is complete, true and accurate.

This signed release allows us to access your personal medical information related to the claim. For the purposes of determining the validity of a claim under this policy, we may obtain and review the medical records of your regular physician(s) at home. Complete the Assignment of Benefits section if you wish to direct payment to a designated person.

SECTION D - OTHER INSURANCE COVERAGE

This section allows us to coordinate payments with any other insurance plans that you may have in addition to this policy such as an employer group benefit plan or coverage on your credit card.

REQUIRED DOCUMENTS

Submit the following documentation to support your claim (please do not staple documents):

- ❑ **Proof of payment including bills and itemized receipts**
  Credit/debit card transaction receipts or credit card/bank statements alone are insufficient. Official pharmacy receipts are required to claim for prescription drugs and must contain the patient's name, date of service, drug name and quantity dispensed.
- ❑ **All medical reports and clinical documentation provided at the time of treatment**
  These documents should include the diagnosis, list of medication given and type of treatment provided.
- ❑ **Proof of travel**
  Provide a copy of your stamped passport, travel itinerary or boarding passes confirming travel dates and entry into Canada.

SUBMITTING YOUR CLAIM

The completed & signed claim forms and applicable supporting documents can be sent to our office by:

❑ **Online:** Visit: **http://manulife.acmtravel.ca**
Create an account and upload your required documents.
Your information is automatically saved and can be reviewed at any time.

❑ **mail**

Canadian Mailing Address	U.S.A. Mailing Address
Active Care Management **P.O. Box 1237** **Station A** **Windsor, ON N9A 6P8**	**Active Care Management** **535 Griswold St** **Suite 111-605** **Detroit, MI 48226**

❑ **e-mail** **TravelClaims@Active-Care.ca**

❑ **By Fax:** **1-877-432-9226**

Please save all original receipts and supporting documentation. ACM reserves the right to request original documents when necessary to adjudicate your claim.

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Your emergency travel medical insurance policy is underwritten by **The Manufacturers Life Insurance Company** ("Manulife"). Manulife has appointed Active Claims Management (2018) Inc., operating as Active Care Management ("Agent" or "ACM"), as the provider of all assistance and claims services under the policy.

IMPORTANT: The Authorization section must be completed in order to process your claim.
By signing this form you certify that the information provided in connection with this claim is complete, true and accurate.

SECTION A – CLAIMANT INFORMATION

Last Name	First Name	☐Male ☐Female	Date of Birth	MM	DD	YYYY
Canadian Address						
Email Address	Primary Phone Number			Secondary Phone Number		
Country of Origin			Date of Arrival in Canada	MM	DD	YYYY
For side-trips outside Canada only Destination:	Travel Dates: MM DD YYYY		To:	MM	DD	YYYY

SECTION B – CERTIFICATION & AUTHORIZATION

- This Authorization will permit Manulife and/or ACM to use the disclosed information for the purpose of determining my eligibility for coverage under my travel insurance policy and discuss any aspect of the adjudication of my claim with Manulife and its affiliates.
- I hereby authorize any doctor, hospital or facility providing medical or health-related services (any of which is a "Provider"), and any other insurer to release and exchange with Manulife and/or ACM or its representative, any information that is required to process this claim.
- For the purposes of discussing payments for medical services provided to me by any Provider, I also fully authorize Manulife and/or its Agent to release and disclose to any such Provider the contents and/or status of the adjudication of any claim for benefits under the Policy. In so doing, Manulife and/or its Agent may release and/or disclose my Medical Records and any adjudication decision, whether interim or final.
- In the event that the person receiving medical services is an unemancipated child, as defined by the laws of the province of my permanent residence, I hereby state that I am the parent/legal guardian of _____ (*insert name*) and that the authorization described above applies to his/her medical records.
- I assign to Manulife 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 Manulife and/or ACM.
- A photocopy, facsimile, or electronic copy of this authorization shall be as valid as the original for the purpose of obtaining further information to process this claim.
- **Notice**: The provincial legislation in some provinces requires us to inform you that the time limit for taking legal action is set out in the Insurance Act or other legislation that applies to your claim.

I certify that the statements and particulars given herein together with those on any accompanying documents or telephone interviews relating to my claim are complete, true and correct to the best of my knowledge.
Manulife and ACM are committed to protecting the privacy, confidentiality and security of the personal information we collect, use and disclose. Your personal information will be used for the purpose of providing you with the requested insurance services. Your personal information may also be used to contact you about your customer experience and/or to participate in market research. For a copy of the privacy policies, please visit: www.manulife.ca and www.active-care.ca.

If claimant is a minor, print full name of parent or legal guardian,
or if claimant is deceased, print full name of executor:

Signature	Date	MM	DD	YYYY

Assignment of Benefits Complete this section if you wish to direct payment to a designated person.

Payee	Phone Number
Payee address	

SECTION C – MEDICAL INFORMATION

Claim Details

Name of Treating Physician or Medical Facility	Phone	Fax		
Description of illness or injury				
Date symptoms first appeared		MM	DD	YYYY
Date treatment first sought		MM	DD	YYYY
Have you ever experienced this sickness or a similar problem before? ☐ No ☐ Yes – When?		MM	DD	YYYY
If the condition was due to a pregnancy, what is the expected date of delivery?		MM	DD	YYYY

Your Medical History – Please list all your medical conditions (if additional lines are required, please attach separate page)

Medical condition	Date diagnosed	MM	DD	YYYY
Medical condition	Date diagnosed	MM	DD	YYYY
Medical condition	Date diagnosed	MM	DD	YYYY
List all medications routinely taken				
Name of Family Physician in Country of Origin	Phone	Fax		
Name of Specialist in in Country of Origin	Phone	Fax		

IMPORTANT: Any reference to testing, tests, test results, or investigations **excludes** genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

Everyone wants to have a carefree trip and should be able to travel with confidence in their travel insurance purchase. Most people travel every day without a problem, but if something does happen, the member companies of the Travel Health Association of Canada (THiA) want you to know your rights. THiA's Travel Insurance Bill of Rights and Responsibilities builds on the golden Rules of travel insurance:

Know your health ● Know your trip

Know your policy ● Know your rights

For more information go to www.thiaonline.com

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SECTION D – OTHER INSURANCE COVERAGE

Do you have Canadian government health insurance? ☐ **No** ☐ **Yes**

Do you or your spouse have any other insurance coverage for out-of-province travel such as an employer group benefit plan, retiree plan or coverage on your credit card? ☐ No ☐ Yes – please specify:

Name of Insurance Company	Policy Number	Certificate Number
If your credit card offers travel insurance, provide the name of the issuing bank		First 6 digits & last 4 digits of credit card

Name of Primary Insured / Name of Cardholder as it Appears on the Card	Date of Birth	MM	DD	YYYY
Signature of Primary Insured / Cardholder	Date	MM	DD	YYYY

If this claim relates to a Motor Vehicle Accident, please provide the following information:

Motor Vehicle Insurance Company	Policy #

If you have claimed with any other insurer, please provide your claim number and attach a copy of the settlement.

SECTION E – EXPENSE SHEET

List all PAID out of pocket expenses. Please save all original receipts. ACM reserves the right to request original documents when necessary to adjudicate your claim.

If you receive additional bills after submission of this claim, please contact our office for additional instructions prior to making a payment.

Facility Name (ex: doctor, pharmacy)	**Description of Expense** (ex: prescription)	**Date of Service**			**Amount Paid**	**Type of Proof of Payment Submitted** Ex: receipt, credit card slip, bank statement. If none, explain below
		MM	DD	YYYY		

If you have additional comments to support your claim, please note them below or submit additional pages.