

PATIENT INFORMATION

Patient Name:		Policy Number:
Date of Birth (dd/mm/yyyy): _____ / _____ / _____ <input type="checkbox"/> Male <input type="checkbox"/> Female		Deductible Amount:
Provincial Health Number [Please attach a photocopy of card]: (including version code for Ontario residents)		Province of Residence:
Departure Date:	Scheduled Return/Termination Date:	Actual Return/Termination Date:
Any extensions of coverage:	Conveyance of Travel: <input type="checkbox"/> Car <input type="checkbox"/> Plane <input type="checkbox"/> Other : _____	Is this claim being made on an annual plan? <input type="checkbox"/> Yes <input type="checkbox"/> No

WHEN RETURNING THIS FORM, PLEASE ENCLOSE THE FOLLOWING DOCUMENTS:

<input type="checkbox"/> Deductible in U.S. Funds	<input type="checkbox"/> All original medical bills and prescription receipts	<input type="checkbox"/> A photocopy of the insured's provincial health card
<input type="checkbox"/> Proof of departure date	<input type="checkbox"/> Completed government health insurance claim forms (B.C. And Quebec residents only)	

(WHEN SUBMITTING ORIGINAL DOCUMENTS, PLEASE BE SURE TO KEEP A COPY FOR YOUR RECORDS)

CO-ORDINATION OF BENEFITS INFORMATION

This section must be completed to ensure prompt handling of your claim

Name, address and telephone number of current employer (if retired, provide name of last employer):		If unemployed at time of loss, check here <input type="checkbox"/>
Name:	Address:	Telephone:
Spouse's Name:	Spouse's Employer:	Spouse's Employer Address:
Please indicate all other insurance you hold through any other insurer (ie. employee/spousal group benefits, retiree group benefits, bank/credit card, benefits purchased with home or auto insurance policy).		
Name of Insurance Company:		
Address:	Telephone:	Does this policy have a lifetime Maximum? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group No.:	Policy/Certificate No.:	If Yes, please state amount: \$
Have you filed any bills with another company? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Company:	Telephone:
Contact Person:		

MEDICAL INFORMATION

Give a brief, clear description of the situation leading to the need to seek medical attention. If the medical services were provided as a result of an accident, please provide us with details of this accident:		
Date of Occurance:	Country where claim occurred:	Do you have any other claims with us for this season? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any of these conditions before?	If "YES", indicate the date you were last treated (includes taking medications):	
Have you paid the account? [If yes please submit proof of payment] <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Full <input type="checkbox"/> Partial	Total amount being claimed : \$ _____ Currency	
Please list all medications in use before your departure date [use a seperate sheet if necessary]:		
Date medications last changed (type or dosage) before your departure date:	Date of your last medical visit:	
Name and telephone number of Family Physician:		

Please complete and sign on the reverse and return within 21 days of receipt of this form.

CERTIFICATION & AUTHORIZATION FOR RELEASE OF INFORMATION (OTHER THAN INSURED)

I certify that the answers given are complete, current and accurate to the best of my knowledge and belief. I hereby authorize any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically relaxation facility, insurance company, Worker's Compensation Board or similar plan or organization, and the Ministry of Health to release and exchange with Medipac Assistance International Inc, and Manulife Financial or representative thereof, my complete medical records, including medical treatment provided by my Primary Care Physician and treatment I received, am about to receive or may receive in the future outside my province of residence. I authorize the period of 12 months, from the date of my notice of claim, as the period of access to and disclosure of my individually identifiable health information in accordance with the Canadian PIPEDA (Personal Information Protection and Electronic Documents Act) and U.S. HIPPA (Health Insurance Portability and Accountability Act) Privacy Practices. A photocopy of this authorization shall be as valid as the original.

I agree that a photocopy or facsimile of this authorization shall be valid as the original and that this authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date it is signed.

I understand I have a right to receive a copy of this authorization.

SPECIAL GOVERNMENT HEALTH INSURANCE PLAN DIRECTION

(Complete if providing consent on behalf of a person who is not capable of consenting to the collection, use and disclosure of personal health information)

I _____,

am the legal decision-maker for _____.

I authorize the Ministry to collect personal health information about the Insured Person, consisting of:

Information relating to the Insured Person's receipt of health care services outside of Canada, and the reimbursement of those services under the Health Insurance Act [R.S.O. 1990, c. H.6, Ontario only]. from Medipac Assistance International Inc., and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying my request for payment under the Health Insurance Act, including the details of any duplicate payment previously made to me, to Medipac Assistance International Inc.

I understand the purpose for the Ministry's collection and disclosure of this personal health information.

I understand that I can refuse to sign this consent form.

Name of Power of Attorney for Insured (Please Print)

Telephone Number

Signature of Power of Attorney for Insured *(Please enclose proof of Power of Attorney)*

Witness Name

Canadian Telephone Number

Witness Signature

Address

Date

Address

Date