MEDIPAC ASSIST

EMERGENCY MEDICAL EXPENSE CLAIM FORM B

to be completed by the legal representative submitting a claim on behalf of an incapable insured

Please print clearly.
All sections must be completed in full.

Policy No.:_____ **Claim No.:** _____

SECTION A. INSURED INFORMATION

Name:	E-mail address:
Date of Birth: (dd/mm/yyyy)	Provincial Health Number:
Primary Phone Number:	Secondary Phone Number:
Actual Departure Date: (dd/mm/yyyy)	Actual Return Date: (dd/mm/yyyy)
Travel Destination:	Mode of Travel to Destination: ☐ Vehicle ☐ Airplane

SECTION B. CLAIM INFORMATION

Was this claim the result of an accident? ☐ Yes ☐ No If you answer Yes, be sure to complete the **Injury/Accident Report**.

Give a brief, clear description of the situation leading to the need to seek medical attention.		
Date of first symptoms: (dd/mm/yyyy)	Date of first treatment: (dd/mm/yyyy)	Country where claim occurred (if different from travel destination):
Did the insured experience this illness or a similar problem before? ☐ Yes ☐ No ☐ Unknown If "Yes," indicate any known details (including treatments, dates and any medications taken for the condition).		

Does the insured have other claims with Medipac this season? ☐ Yes ☐ No ☐ Unknown

SECTION C. MEDICAL HISTORY (complete to the best of your ability)

Name and telephone number of family physician:		Date of last visit to family physician:
Specialists Name:	Telephone Number:	Specialty Type:
Specialists Name:	Telephone Number:	Specialty Type:

List any medications taken or prescribed before the insured's departure date (use a separate sheet of paper if necessary)

MEDICATION	DOSAGE	DATE OF LAST DOSAGE CHANGE

GENERAL CLAIM INQUIRIES: 1-888-311-4761

SUBMIT TO: MEDIPAC ASSIST CLAIMS DIVISION, 180 LESMILL ROAD, TORONTO, ON M3B 2T5

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SECTION D. OTHER INSURANCE INFORMATION (complete to the best of your ability)

Does the insured have Medicare coverage? ☐ Yes ☐ No	
If Yes, what type? ☐ A only ☐ B only ☐ A and B	Medicare No. (if applicable):
Does the insured have any out-of-country medical insurance or benefits available through their employer or their spouse's employer? ☐ Yes ☐ No	
If Yes, Name of Insurance Company:	Policy/Cert./ID No:
Name of employer/ retirement plan	Does the policy have a lifetime maximum of $100,000 or less? ☐ Yes ☐ No
If through spouse's employer, Name of Spouse	Name of spouse's employer/retirement plan
Credit cards may include travel benefits. Was a credit card used for any travel arrangements (including flights, hotels, cruises and car rental)? ☐ Yes ☐ No	
Name of the issuing bank:	First 6 digits & last 4 digits of card:
Name of Primary Insured/ Name of Cardholder as it appears on the card:	Date of Birth: (dd/mm/yyyy)
Signature of Cardholder as it appears on the card:	Date
Does the insured or their spouse have any benefits available through any other travel insurance company or supplier? ☐ Yes ☐ No	
If Yes, Name of Insurance Company:	Telephone Number:

Has a claim been made with any other insurer? ☐ Yes ☐ No
If yes, attach a copy of any payments made and provide the claim number:

GENERAL CLAIM INQUIRIES: 1-888-311-4761

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SECTION E.

CERTIFICATION & AUTHORIZATION FOR RELEASE OF INFORMATION

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 related facility, insurance company, Worker's Compensation Board or similar plan or organization, and the Ministry of Health to release and exchange with Medipac International Inc., Medipac Assistance International Inc. (Medipac Assist) and Old Republic Insurance Company of Canada, or representatives thereof, complete medical records, including medical treatment provided by any Primary Care Physician, treatment which has been received, or will be received in the future. I authorize the period of 12 months, from the date of this notice of claim, as the period of access to and disclosure of the individually identifiable health information for the insured in accordance with the Canadian PIPEDA (Personal Information Protection and Electronic Documents Act) and U.S. HIPAA (Health Insurance Portability and Accountability Act) Privacy Practices.

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

NOTE: 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.

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. However, this claim can not be processed without a fully completed claim form.

X _____
Name of legal decision maker for the Insured *(Please Print)*

X _____
Address

X _____
Canadian Telephone Number

X _____
Other Telephone Number

X _____
Signature of legal decision maker for the Insured

X _____
Date

X _____
Witness Name

X _____
Address

X _____
Canadian Telephone Number

X _____
Other Telephone Number

X _____
Witness Signature

X _____
Date

GENERAL CLAIM INQUIRIES: 1-888-311-4761

SUBMIT TO: MEDIPAC ASSIST CLAIMS DIVISION, 180 LESMILL ROAD, TORONTO, ON M3B 2T5

Underwritten by Old Republic Insurance Company of Canada