ORION TRAVEL INSURANCE™

Visitors to Canada Medical Claim Form

Policy No.:_____ Claim No.:_____

Section A - Policyholder's Information (if different from claimant's)

Last Name	First Name	Initials	❍ Female ❍ Male
Date of Birth _____ /_____ /_____ (M/D/Y)	Email		
Address (Number & Street)			
City	Province	Postal Code	
Phone Number	Alternate Phone Number		

Section B - Insured Person/Claimant Information (Please print)

Last Name	First Name	Initials	❍ Female ❍ Male
Date of Birth _____ /_____ /_____ (M/D/Y)	Relationship to Policyholder		
Canadian Address (Number & Street)			
City	Province	Postal Code	
Phone Number	Alternate Phone Number		
Email	Preferred Method of Communication (check all that apply) ❍ Email ❍ Phone ❍ Mail		

Section C - Travel Details

Country of Origin	Arrival in Canada _____ /_____ /_____ (M/D/Y)	Planned Return Date _____ /_____ /_____ (M/D/Y)
Temporary Trip outside Canada Destination:	Departure Date _____ /_____ /_____ (M/D/Y)	Return Date _____ /_____ /_____ (M/D/Y)

Section D - Medical Information about the Claimant

Please describe briefly why medical attention was sought	
When did the symptoms first appear? _____ /_____ /_____ (M/D/Y)	If the condition was due to a pregnancy, provide the expected date of delivery: _____ /_____ /_____ (M/D/Y)
When did you first seek treatment? _____ /_____ /_____ (M/D/Y)	Have you ever experienced this illness or similar problem before? ❍ No ❍ Yes
Name of Medical Facility where you consulted	Telephone Number of Medical Facility

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

Medical condition	Date diagnosed _____ /_____ /_____ (M/D/Y)
Medical condition	Date diagnosed _____ /_____ /_____ (M/D/Y)
Medical condition	Date diagnosed _____ /_____ /_____ (M/D/Y)
List all medications routinely taken:	

Name of Family Physician in Country of Origin	Phone Number	Fax

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Section E- Other Insurance

This insurance pays eligible expenses in excess of those covered by any other insurance. If, at the time of loss, you have similar coverage with another provider (i.e. credit card, travel insurer, employment group health plan, private or provincial, auto plan, U.S. medicare, etc.), we will coordinate benefits in accordance with the CLHIA guidelines.

Do you have Canadian government health insurance? ❍ No ❍ Yes

Do you and/or your spouse or child have other travel insurance benefits?

Employer, retiree, or other group plan: ❍ No ❍ Yes If yes, please complete Section 1 below
Credit card: ❍ No ❍ Yes If yes, please complete Section 2 below
Any other coverage: ❍ No ❍ Yes If yes, please complete Section 3 below

Section 1 - Employer, Retiree or Other Group Plan

Insurance Company		Phone No.
Policy No.	ID No.	Name of the Insured

Section 2 - Credit Card

Issuing Bank	Card No. (First 6 Last 4 digits)

Section 3 - Other Coverage

Insurance Company	Policy No.

Are you covered by U.S. Medicare? ❍ Yes ❍ No
❍ Type A ❍ Type B ❍ Both Enrollment Number:

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

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Section F - Declaration / Authorization / Signature

- The Insurer, its Agents and Administrators are obliged to collect and retain certain personal information 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 certify that the information I provided is true and correct to the best of my knowledge. I understand that this claim shall be void if, whether before or after the loss, I concealed or misrepresented any facts, or if any documents received regarding this claim have concealed or misrepresented any fact or circumstances concerning this claim.
- I 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 Orion Travel Insurance Company, and its representatives employed to assist in the administration of the claim, any information, including personal information, data or records that are in their possession/knowledge regarding my medical history and treatment.
- I hereby consent to the use by Orion, 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 of insurance for the purposes cited above. This consent is effective for one year form the date of services provided and may revoke this consent in writing at any time by advising Global Excel.
- I authorize Orion Travel Insurance Company and Global Excel, to coordinate the payment of benefits with any other insurance carriers which may also have a liability for this claim. I hereby irrevocably direct Orion Travel Insurance Company and Global Excel, to make any payments, receive payments and settle with other carriers on my behalf.
- Attention to Travel Service Providers: I hereby authorize and direct that you release to Orion Travel Insurance Company or its representative any and all information you have regarding my travels or use of your travel services for the purpose of determining my eligibility for coverage and or for benefits under my Orion Travel Insurance Policy.
- 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.
- I authorize Global Excel Management (Global Excel) to deposit all personal claim payments directly to the account indicated on this form.

Insured Name: _____

Insured Signature: ✍ _____ **Date** ____ /____ /____ **(M/D/Y)**

If I am not the Insured Person:

- **Use this section if you are completing the claim form on behalf of someone else.**
- In providing this authorization to collect personal information about the Insured Person relating to this claim, I the undersigned do hereby certify that I have appropriate permission from the Insured Person to authorize the collection, use and disclosure of their personal information as authorized above and that the Insurer and its agents and reinsurers may rely and act upon my authorization.
- 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 and that the authorization described above applies to his/her medical records.

Authorized Person's Name: _____

Relationship to the Insured Person: _____

Authorized Person's Address: _____

Authorized Person's Signature: ✍ _____ **Date** ____ /____ /____ **(M/D/Y)**

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Section G - Incurred Expense List

No.	Name of Clinic, Doctor, Dentist, Hospital, Pharmacy	Description of Expense	Date	Amount Billed	Amount Paid	Outstanding Balance	Currency	Receipt included (Check the appropriate box)
1								❍ Yes ❍ No
2								❍ Yes ❍ No
3								❍ Yes ❍ No
4								❍ Yes ❍ No
5								❍ Yes ❍ No

Comments

Clearly indicate which invoice(s) have been paid. Keep a copy of this form (as well as copies of all supporting documents) for your records.

The processing of your claim will be delayed for any of the following reasons:

- A delay in receiving medical information from your treating doctor or physician.
- A delay in receiving medical records from the treating facility at your travel destination.
- An incomplete claim form.
- Insufficient (or incorrect) supporting documentation.

It is possible that you could receive invoices or reminder notices directly from the health care providers you consulted while travelling. Should this occur, please forward these notices to Global Excel Management. Should you receive any phone calls regarding your invoices, please direct the caller(s) to Global Excel Management.
We request that you not pay any medical accounts directly to providers, unless you have been advised to do so by Global Excel Management.

Section H – Preferred Method of Reimbursement

Note: If a method of reimbursement is not selected, eligible reimbursements under this policy will be issued by cheque.

Assignment of Benefits

If you wish to direct payment to a designated person other than the claimant, please provide their name, address and phone number below.

Payee Name: _____ Phone Number: _____

Address: _____

❍ **Direct deposit (CAD only).**

By providing your banking information, your claim payments will be deposited directly to your account and you will get an email notification when your claim is settled.

Transit Number: Institution number: Account Number:

❍ **Cheque**

This policy is underwritten by Orion Travel Insurance Company. Orion Travel Insurance Company (Orion) has appointed Active Claims Management (2018) Inc., operating as "Active Care Management", "ACM", "Global Excel Management" and/or "Global Excel" as the provider of all assistance and claims services under this policy.