SECURE TRAVEL VISITORS TO CANADA

CLAIM FORM

INSTRUCTIONS

IMPORTANT

- In the event of hospitalization, MSH Assistance™ ("Assistance") must be notified prior to, or within 24 hours of, admission to hospital.
- Assistance is to approve, in advance, all tests, procedures or treatments.
- It is your responsibility to ensure that Assistance is notified in advance of any surgery or invasive investigations. Do not assume that someone will contact Assistance on your behalf.
- All claims must be reported to Assistance within 30 days of occurrence. Written proof of claim must be submitted to Assistance within 90 days of occurrence.
- You are responsible for all fees charged for completion of this form and any supporting documentation.

CLAIMS SUBMISSION

- To complete the claim submission, patients must obtain and submit to Assistance a copy of the emergency room report and all hospital records if treated at a hospital. For patients treated at a medical clinic, medical centre or by a family physician, a physician's medical report is required for claim submission.
- If you have paid for services, you must submit all original itemized invoices and payment receipts from the medical service provider or hospital detailing treatment and treatment dates. Photocopies of receipts will not be accepted.
- Complete all sections and ensure this form is signed before submitting to Assistance with all original invoices, physician and medical reports, and original prescription pharmacy receipts.
- Failure to complete and sign this form in its entirety, or to submit supporting documentation, will delay processing of your claim.

SECTION A: CLAIMANT INFORMATION

CLAIMANT

Claimant's First Name | Claimant's Last Name | Policy Number

Date of Birth (DD/MM/YY) ☐ Male ☐ Female ☐ Non-binary

Arrival Date in Canada (DD/MM/YY) | Scheduled Departure Date From Canada (DD/MM/YY)

CLAIMANT'S MAILING ADDRESS IN CANADA

Unit # | Street Address

City | Province | Postal Code

Phone | Email

CLAIMANT'S FAMILY DOCTOR IN HOME COUNTRY (IF APPLICABLE)

Full Name | Clinic Name or Practice

Unit # | Street Address

City | State/Province | Country | ZIP/Postal Code

Phone | Fax

TREATING PHYSICIAN FOR THIS CLAIM

Full Name | Clinic Name or Practice

Unit # | Street Address

City | Province | Postal Code

Phone | Fax

SECTION B: OTHER INSURANCE COVERAGE

Does the claimant currently have provincial or government insurance coverage of any kind? ☐ Yes ☐ No

IF NO, has the claimant applied for government coverage of any kind? ☐ Yes ☐ No

Is the claimant covered by another medical or travel insurance policy (including coverage through a spouse, parent, or guardian)? ☐ Yes ☐ No

IF YES, provide details of other insurance coverage below.

Full Name of Policyholder	Insurance Company			
Policy/Plan Number	ID/Certificate Number	Employer Group Number (if applicable)	Employer Name (if applicable)	Employer Phone (if applicable)

SECTION C: CLAIM INFORMATION

Description of claimant's sickness or injury (if this space proves insufficient, additional information can be attached):

Date symptoms first appeared or the injury occurred (DD/MM/YY):

Has the claimant previously been treated for this, or a similar or related, condition? ☐ Yes ☐ No

IF YES:

Date the claimant first saw a physician for this, or a similar or related, condition (DD/MM/YY):

Provide all dates of treatment and list all medications taken for this, or a similar or related, condition before the effective date of the current policy:

Treatment Date (DD/MM/YY)	Medication

SECTION D: EXPENSES CLAIMED

Name of Provider	Diagnosis	Date of Service (DD/MM/YY)	Amount Billed ($)	Amount Paid ($)

SECTION E: AUTHORIZATION AND CERTIFICATION

Industrial Alliance Insurance and Financial Services Inc. ("Industrial Alliance"), MSH Assistance™ ("Assistance"), its agents, and administrators, are obliged to collect and retain certain personal and/or health information about you in connection with your insurance coverage. We use and disclose this information only for the purposes of administering your policy/policies of insurance, providing customer service, and in assessing and paying claims. We are committed to protecting the privacy, confidentiality, and security of the personal information we collect, use, retain, and disclose. Your personal information will be used only for the purposes of providing you with the requested insurance services. Industrial Alliance's and Assistance's complete privacy policies are available upon request.

I authorize any doctor, medical practitioner, hospital, facility providing medical or health-related services, third-party administrator, provincial plan and any other insurer to release and exchange with Industrial Alliance, Assistance, or its representatives, any information (including personal health data and records) required to process this claim. I authorize any third party providing me with assistance in this claim process to have access to any and all relevant claims information related to the adjudication of my claim with Industrial Alliance and Assistance. I authorize Assistance to coordinate the payment of benefits with any insurance carriers that may have a liability for this claim and assign to Industrial Alliance and Assistance any benefits payable from any other sources for losses covered under this policy, and authorize and direct such payers to forward payment directly to Industrial Alliance and Assistance. I confirm below by my signature that I am authorized to act on behalf of any 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 insured (please print): _____

If applicable, I authorize payment of this claim to (please print): _____

_____

Signature of insured (if insured is a minor, signature of parent or legal guardian)

_____

Signature of policyholder of other insurance in Section B (if applicable)

Date (DD/MM/YY): _____

SECTION F: AUTHORIZATION TO PAY

THIS CLAIM IS PAYABLE TO:

☐ Insured at the address in Section A above ☐ Parent/Guardian ☐ Hospital/Clinic ☐ Physician

☐ Other: If applicable, I authorize payment of this claim to: _____

PAYMENT METHOD

☐ Cheque ☐ Electronic Funds Transfer (For EFT payments, complete fields below and check for accuracy: example here)

Account Holder Name	Transit Number (5 digits only)	Financial Institution (3 digits only)	Account Number (7 digits only)

IN THE EVENT OF AN EMERGENCY PLEASE CONTACT MSH ASSISTANCE™ IMMEDIATELY AT:

+1-800-203-8508
toll-free from Canada and the USA
e-mail: MSHAssistance@mshassistance.com

+1-416-646-3107
collect where available

CLAIMS SUBMISSION:

MSH Assistance™
150 King St West, Suite 602 - PO Box 75
Toronto, ON M5H 1J9 Canada

e-mail: MSHClaims@mshassistance.com
fax: +1-416-730-1878