ONEWORLD ASSIST

DOCUMENTATION REQUIREMENTS

VISITORS TO CANADA

Below is a list of required claim forms and additional information, needed to process your recent claim. Please review each item carefully and complete it as accurately and as fully as possible. Be sure to sign each form as indicated. In addition, provide all ORIGINAL receipts, bills and/or prescription receipts.

Please provide the following documents and information:

- ☑ **Visitors Medical claim form**
  - Please fully complete this form.
  - All questions, including 1 – 6 on the bottom of the form MUST be answered.
  - The 'Medical Authority' on the back side of the claim form MUST be signed.

- ☑ **All ORIGINAL, itemized bills/receipts**

- ☑ **All ORIGINAL prescription drug receipts** (pharmacy issued tax or customer receipts).

- ☑ **Proof of payment**
  - If you have already paid the medical provider or facility directly, please provide proof of the amount paid so we can process your reimbursement.
  - For example, "paid" receipt from the provider, credit card statement, copy of a cancelled cheque, etc.

- ☑ **Written statement (if your claim is related to an ILLNESS)**
  - Please provide a written statement detailing the diagnosis or the nature of the illness you are claiming for.
  - Wherever possible, please include the dates and times of your consultations, and the name, address and telephone number of the physician/facility that treated you.
  - **If this information does not fit in Question 1 on the claim form, please use the back of claim form.

- ☑ **Written statement (if your claim is related to an INJURY)**
    - o Please provide a written description of the event which caused your injury. Be sure to include the date and time of the incident as well as the name, address and telephone number of who you feel is responsible.
    - o If possible, please also include the name, address and telephone number of the physician/facility that treated you for the injury.
    - o **If this information does not fit in Question 1 on the claim form, please use the back of claim form.

In the unfortunate event you are filing a claim for someone who has passed away, please also submit:

- ☑ A copy of the Insured's Death Certificate.

- ☑ A copy of the section of the Will which designates who will be acting on behalf of the Estate (i.e. who is the Executor).

- ☑ The original receipts for cremation or for homeward carriage for burial, if these expenses were incurred while the Insured was travelling.

As we are unable to process your claim until this information is received, please provide all of the requested information as soon as possible.

Thanks for your assistance.

OneWorld Assist looks forward to resolving your claim.

Visitors to Canada Medical Claim

ONEWORLD ASSIST

This form will be returned if both sides are not completed in full

OneWorld Assist, 10th Floor, 6081 No.3 Road
Richmond, BC Canada V6Y 2B2
Tel: 604-278-4108 **Fax**: 604-276-4593
Canada & USA Toll Free: 1-800-663-0399

Claim No.

ISO 9001 REGISTERED

CANADA'S BEST MANAGED COMPANIES

(Please print clearly)

Name of the Insured claiming FIRST NAME FAMILY NAME ❍ M ❍ F

Address _____ City _____ Prov. _____

Postal code _____ Telephone: Home [ ] _____ Office [ ] _____

Date of birth M | D | Y Country of residence _____

Arrival date in Canada M | D | Y Planned departure date from Canada M | D | Y

Travel insurance policy no._____ Effective date M | D | Y

Begin with the first medical treatment in Canada (or U.S. and Mexico if applicable) and specify the Sickness(es) or Injury treated/medical diagnosis, date of treatment, physician's name, cost of treatment and drugs prescribed.

Date of Treatment	Sickness/Injury & Service Provided	Attending Physician's Name	Cost of Treatment	Drugs Prescribed
(eg.) Jan 1 2009	Rash on arm—consultation	Dr. Jones	$55	Fucidin

1. Please provide a brief description of how, when and where the sickness or injury occured _____

2. If hospitalized overnight: Name of hospital _____ Prov. _____
   Date of admission M | D | Y Date of discharge M | D | Y

3. Have you been treated for the listed sickness(es) before? ❍ Yes ❍ No
   If "Yes", please provide the date(s) and place(s) of previous treatment _____

4. Please provide the name, address and phone number of your most recent physician before your arrival in Canada.

5. Were you taking any prescribed drugs or medications prior to the effective date of your policy? ❍ Yes ❍ No
   If "Yes", please list the names of these drugs or medications _____

6. Are you covered under any other medical insurance plan, either private or provincial? ❍ Yes ❍ No If "Yes", please provide:
   Name of plan _____ Plan, policy or contract no. _____ Effective date M | D | Y

7. If you prefer that reimbursement be made payable to someone other than yourself, please print their name below, and provide your signature as authorization.

Name of payee _____ Relationship to Insured _____

Signature of Insured X _____ **Date** M | D | Y

PLEASE SEE REVERSE SIDE FOR ADDITIONAL REQUIRED SIGNATURE

FAILURE TO PROVIDE ALL INFORMATION REQUESTED IN THIS FORM AND SIGNED MEDICAL AUTHORITY MAY CAUSE EXTREME DELAYS IN PROCESSING YOUR CLAIM.

Please ensure that this completed form is returned promptly to OneWorld Assist Inc. with signed Medical Authority.

MEDICAL AUTHORITY

AUTHORIZATION TO PHYSICIANS, HOSPITALS AND OTHER MEDICAL PROVIDERS

(This form will be returned to the sender if not completed and signed as indicated.)

1. I authorize all hospitals, physicians, medical care providers, insurers and other persons, from all countries, to provide to OneWorld Assist Inc. ("OWA") all information and documentation in their possession that OWA requires to process my claim, including: records in regard to illnesses, injuries, medical history, consultations, medicines and treatments of the claimant named below (collectively, the "Medical Records").
2. I authorize OWA to collect, use and disclose the Medical Records, and the information in the Medical Records, to the selling agent, and to any insurers, including government health plans, that may have a responsibility in this claim.
3. I understand that the purpose for the collection, use and disclosure of the Medical Records is to enable OWA and insurers to assess and determine the eligibility of any claim I might submit. I acknowledge and agree that it is my responsibility to provide to OWA such information and other documentation as may reasonably be required to process my claim and that my failure to do so will jeopardize my entitlement to coverage.
4. I understand that if Medical Records are required from the U.S., this purpose constitutes a payment operation under the privacy rules in the U.S. Health Insurance Portability and Accountability Act.
5. This authorization takes effect on the date set out below. I understand that I may revoke this authorization in writing. I acknowledge and agree that if this authorization is revoked before the Medical Records are collected and reviewed my entitlement to insurance coverage will be jeopardized.

A copy of this authorization received from OWA shall be as effective and valid as the original.

FIRST NAME FAMILY NAME

Print name **(and relationship if not claimant)**

X _____

Signature **(Claimant or authorized representative)**

M | D | Y

Date