VISITORS TO CANADA EMERGENCY HOSPITAL & MEDICAL INSURANCE CLAIM FORM

Submit Claims to:

SelectCare Worldwide Claims Department 2100 – 250 Yonge Street

2100 – 250 Yonge Street Toronto, Ontario, Canada M5B 2L7 Phone: 1-866-261-4441 Fax: 416-340-7152

INSTRUCTIONS

IMPORTANT

- In the event of hospitalization, SelectCare Worldwide® (SCW) must be notified prior to, or within 24 hours of admission to hospital and prior to any surgery or invasive investigations being performed.
- All claims must be reported within 30 days of occurrence.
- Written proof of claim must be submitted within 90 days of occurrence.
- You are responsible for any fees charged for completing this form or issuing supporting documentation.

REQUIREMENTS

- Fully completed and signed Claim Form, sections A, B, C & D.
- Completed Attending Physician/Dentist Statement, Section E.
- Emergency room report and/or hospital records if treated at a hospital/outpatient facility.
- All original bills and/or receipts. Photocopies will not be accepted.
- All bills must be itemized and show dates and costs of all treatment received.

Insured's First Name:		Last Name:		
☐ Male ☐ Female	Date of Birth: MM/DD/YYYY	Policy #:		
Address in Canada Street Address:				
City/Town:		Postal Code:		
Telephone: ()		Email:		
Country of Origin:		Date of Arrival in Canada: MM/DD/YYYY		
Name and Address of Family Physician in Country of Origin		Name:		
Street Address:				
City/Town:		Postal Code: To	elephone: (
Name and Address of Family Physician in Canada		Name:		
Street Address:				
City/Town:		Postal Code: To	elephone: ()	
Nama	address of other insurance company/cov			
City/Town:		Postal Code: To	elephone: (
SECTION B: MEDICAL INFORM	MATION			
Brief description of sickness or in	jury:			
Brief description of sickness or in	jury:			
Date symptoms or injury first app				/ D D / Y Y Y Y
Date symptoms or injury first app Have you ever been treated for th If 'Yes', give all dates of treatmen Date: MM/DD/YYYY	peared: MM/DD/YYYY Danis or a similar condition before?	□ No		/ D D / Y Y Y Y
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SECTION D: AUTHORIZATION AND CERTIFICATION (CONTINUED ON NEXT PAGE)

SCW is committed to protecting the privacy, confidentiality and security of the personal information we collect, use and disclose. Your personal information will be used only for the purpose of providing you with the requested insurance services. For a copy of SCW's privacy policy, please contact us.

SECTION D: AUTHORIZATION AND CERTIFICATION (CONTINUED FROM PREVIOUS PAGE)

I authorize any doctor, hospital or facility providing medical or health related services, and any other insurer to release and exchange with SCW or its representatives, any information that is required to process this claim. I assign to SCW any benefits payable from any other sources for losses covered under this policy, and I authorize and direct such payors to forward payment directly to SCW. I also authorize any third party providing me with assistance in this claims process, to have access to any and all relevant claims information related to the adjudication of my claim with SCW. I confirm I am authorized to act on behalf 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. Date: MM/DD/YYYY Full Name of Patient/Insured (please print): I authorize payment of this claim to (print name): Signature of Insured (if minor, signature of parent or legal guardian): Signature of policy holder of other insurance in Section A (if applicable): SECTION E: ATTENDING PHYSICIAN/DENTIST STATEMENT Date of Birth: MM/DD/YYYY Name of Patient: Date of First Consultation: MM/DD/YYYYY Diagnosis Claimed For: When did symptoms for this condition, or injury first occur? MM/DD/YYYY Has the claimant/patient ever had the same or similar condition during the 12 months prior to this visit? \Box Yes \Box No If 'Yes', please advise: Date(s) of all medical visits: MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY Diagnosis: **Treatment Rendered:** 3. Was the claimant/patient referred to you? \(\begin{align*} \Pi \text{ Yes } \Pi \text{ No } \end{align*} If 'Yes', please provide the name/address of referring physician: Are you aware of any other physician in Canada who may have treated this claimant/patient for this or a similar condition? \square Yes \square No If 'Yes', please provide the name/address of this physician: Describe any other diseases or infirmity affecting the condition being claimed for: List all medication(s) claimant/patient was taking at the time of initial consultation: 7. Was the claimant/patient hospitalized?

Yes

No

If 'Yes', name of hospital: Date of Admission: MM/DD/YYYY Date of Discharge: MM/DD/YYYY 8. Was any surgery performed? ☐ Yes ☐ No If 'Yes', please provide name and address of surgeon/hospital: 9. Was this condition due to pregnancy? ☐ Yes ☐ No If 'Yes', date of last menstrual period MM/DD/YYYY and expected date of delivery: MM/DD/YYYY 10. Was this condition due to the use of alcohol, misuse of drugs, or self-inflicted injury? ☐ Yes ☐ No If 'Yes', please give details: 11. Was this condition due to a motor vehicle accident? ☐ Yes ☐ No If 'Yes', date of accident/injury: MM/DD/YYYYY 12. In your opinion, could treatment for the condition have been postponed until the patient's return to country of origin? \Box Yes \Box No If 'No', please provide details, and date the insured would be medically certified as fit to travel:

PHYSICIAN'S CERTIFICATION AND SIGNATURE

I certify that the information provided in this section is complete, true and accurate to the best of my knowledge and belief

receiting that the information provided in this section is complete, true and accurate	to the best of my knowledge and belief.
Physician's Signature:	PHYSICIAN'S STAMP HERE
Physician's Name (please print):	_
Date: MM/DD/YYYY Email:	_
Street Address:	_
City/Town: Postal Code:	_
Telephone: () Fax: ()	_



Date fit to Travel: MM/DD/YYYY