

CLAIM AND AUTHORIZATION FORM

CLAIM # _____

CUSTOMER INFORMATION

Full Last Name: _____ First Name: _____ Date of Birth: _____
 Address: _____ Apt. #: _____
 City: _____ Province: _____ Postal Code: _____
 Telephone: Home: _____ Business: _____ Policy #: _____
 Government Health Insurance Plan#: _____ Amount claimed: _____ Currency: _____

CLAIM AND TRIP INFORMATION

Departure Date: _____ Return Date: _____ Date of Occurrence: _____
 Patient's Name: _____ Patient's Relationship to Insured: _____
 Location of Occurrence: (City/Town): _____ Country: _____
 Name of your Canadian Physician(s): _____
 Address: _____ Tel: () _____ Fax: () _____
 City: _____ Country: _____ Postal Code: _____

POWER OF ATTORNEY

I THE UNDERSIGNED, _____ empower RBC Insurance Company of Canada located at PO Box 97, Station A, Mississauga, ON, L5A 2Y9 to:
 (In Block Letters)

- Submit to the Régie de l'assurance maladie du Quebec (the Régie), in accordance with the laws and regulation applied by the Régie, my claims for insured medical services which I, my spouse or my children received (family insurance) in _____ (location) during our stay from _____ to _____

Family Insurance: For the purposes of family insurance, this Power of Attorney applies only to me, my spouse and my children, identified below:

- Spouse _____ Health Insurance Number: _____
- Children _____ Health Insurance Number: _____
 _____ Health Insurance Number: _____

- Transmit to, and receive from, the Régie all information and documents required for the assessment and payment of said claims.
- Receive from the Régie all amounts reimbursed and due to me, my spouse or my children (family insurance).

I AUTHORIZE the Régie to accept the claims so submitted, to act in accordance with this Power of Attorney as specified and to transmit to the company any information may request concerning the insured person status of myself, my spouse or my children.

 Insured person's signature

 Insured person's Health Insurance Number

 Policy or claim number

(This number corresponds to the one which must appear on the Statement of payments and reimbursements)

**ATHORIZATION TO PHYSICIANS, HOSPITALS AND OTHER MEDICAL PROVIDERS AND SPECIAL
AUTHORIZATION AND DIRECTION**

1. I authorize you to give RBC Insurance Company of Canada any and all information you have regarding me, while under observation or treatment by you, including my medical history, diagnoses and test results, and I hereby consent to the disclosure of such information by RBC Insurance Company of Canada to other sources as may be required for the processing of my claim for benefits obtainable from other sources.
2. I hereby assign to RBC Insurance Company of Canada any benefits obtainable from other sources for losses covered under this policy. I also direct these sources to forward payment to RBC Insurance Company of Canada for my claim submitted by RBC Insurance Company of Canada with regard to these losses. A photocopy or faxed copy of this authorization is acceptable.
3. I understand my claim may be subject to review and investigation and I give RBC Insurance Company of Canada or their authorized agents authority to acquire any documents or statements from other insurers, financial institutions, travel suppliers, any company or public/private organization which can provide information related to my claim, and I hereby consent to the disclosure of such information by RBC Insurance Company of Canada to other sources as may be required for the processing of my claim.

Claimant's/Patient's Name: _____ Date: _____

(Please Print)

I authorize RBC Insurance Company of Canada to direct payment to: _____ who has pre-paid my expense(s).

Claimant's/Patient's Signature: _____ Date: _____

(if Patient is not a minor, Patient must sign this section)

OTHER INSURANCE INFORMATION

(This section must be completed by the insured person. If the insured is a minor, the parent/legal guardian must complete this section)

Do you have group benefits through (check all that apply and provide details):

Your Employer Your Spouse's Employer A Retiree Plan

Name of Plan Member/Employee/Retiree: _____ Date of Birth: M _____ D _____ Y _____ Policy/Plan #: _____

Name of Employer/Group: _____ ID #(Employee #, Certificate #, etc.): _____

Name & Address of Insurance Company: _____

Name of Spouse: _____ Date of Birth: M _____ D _____ Y _____ Policy/Plan #: _____

Name of Employer/Group: _____ ID #(Employee #, Certificate #, etc.): _____

Name & Address of Insurance Company: _____

Do you have benefits available through any other Travel Insurance Company or Travel Supplier? Yes No

If yes, Name & Address: _____

Do you have benefits available through (check all that apply): Home Insurance? Auto Insurance? Other? _____

Policy #: _____ Name & Address of Insurance Company: _____

Do you have a Bank Credit Card? (some credit cards have travel benefits) Yes No

If yes, please provide the card # _____ Name of Financial Institution: _____

Is there a co-applicant? Yes No If yes, Name : _____

I hereby warrant that I do not have any other travel or out-of-province medical insurance coverage.

Claimant's Signature: _____ Date: _____