

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: _____

PROVINCIAL GOVERNMENT HEALTH INSURANCE PLAN (GHIP) AUTHORIZATION AND RELEASE

Government Health Insurance Plan # _____ Version Code: (Ontario Only) _____

I agree that, pursuant to the terms of this policy and in respect of my applicable provincial health insurance legislation pertaining to freedom of information and protection of privacy; and in consideration for any monies RBC Insurance Company of Canada may advance to me as a result of the issuance of this policy, I hereby irrevocably:

1. direct and authorize GHIP to make payment in respect of my claim for out-of-country health services to RBC Insurance Company of Canada directly and I hereby release GHIP upon payment to RBC Insurance Company of Canada from any further claim or cause of action in connection therewith; and
2. consent and authorize GHIP to directly collect information contained in the claim and source documents (pursuant to section 39(1) of the Freedom of Information and Protection of Privacy Act, and 4(2) of the Health Insurance Act, in Ontario only, and
3. consent to the disclosure by GHIP to RBC Insurance Company of Canada of such personal information as may be necessarily required for the processing of my claim for out-of-country health services, including the details of any duplicate payment made directly to me or on my behalf.

Claimant's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

AUTHORIZATION 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: _____