CLAIM AND AUTHORIZATION FORM

CLAIMANT INFORMATION - MEDICAL

Last Name:	First Name:	Date of Birth:
Address:		
City:	Province:	Postal Code:
Home Phone:	Mobile Phone:	
Email Address:		

'*You*' or '*Your*' refers to the primary insured named on this claim form. If the Primary insured is a minor, the parent or legal guardian is referred to as '*You*' or '*Your*'

Please select your preferred method of contact: Email ☐ Home Phone ☐ Mobile Phone ☐

If you selected 'Home Phone' or 'Mobile Phone'; please advise the best time/day to be reached between Monday – Friday 8AM – 5PM EST

Enter Time: _____ Prefered day: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

(by selecting your preferred method of contact, you are providing consent for RBC Insurance Company of Canada to discuss your claim information via phone or email)

CANADIAN FAMILY DOCTOR AND/OR SPECIALIST INFORMATION

Your medical history may be required to fully review your claim. Please provide your Canadian Physician(S) information below

Family Physician(s):	Telephone:
Walk-in Clinic (if applicable):	Telephone:
Canadian Specialist(s):	Telephone:

CLAIM DETAILS

1. Trip Departure Date: _____ Trip Return Date: _____

2. The date you sought medical attention: _____

3. The reason for seeking medical attention (diagnosis):

4. If you incurred eligible expenses and your claim is payable, should the cheque be made out in your name?

◯ YES - The Claim will be paid out to me

◯ NO - Please provide name and address of whom the claim should be paid out to:

Name:	
Address:	

OTHER INSURANCE INFORMATION

1. Please enter your Provincial Health Insurance Plan Card Number:

   Version code (Ontario Only):

   Some Ontario residents have 1 or 2 Alpha letter(s) added at the end of their OHIP Card Number

2. Are you, or your spouse, entitled to benefits under any other plan for the medical expenses being claimed?

YES ◯
NO ◯

If YES, please provide details below; if NO, leave blank and complete the next section;

	You	Your spouse
Name of Insurance Company:		
Plan Number:		
Plan Member ID Number:		

If spouse's plan, please provide spouse's name:

and date of birth:

3. Do you have a Credit Card? ◯ YES ◯ NO

If YES, please provide details below;
To help you receive all additional payments you are entitled to, we will coordinate with any other potential Insurers on your behalf. We will determine if the card provides coverage for your incident.

Credit Card Number:		Type of Credit Card:	

LIST OF SUBMITTED EXPENSES - MEDICAL

List eligible expenses you paid for below: (i.e. prescriptions, Dr. visit, meals, ambulance, etc.)	Date Incurred	Amount	Currence expenses paid in	Original Receipts Enclosed Yes/No

* Please attach another sheet if your expenses exceed the space provided

* If your amounts are in more than one currency, please total each separately

Total Amount: _____ Currency: _____

Total Amount: _____ Currency: _____

POWER OF ATTORNEY - MEDICAL

I THE UNDERSIGNED,

empower RBC Insurance Company of Canada located at PO Box 97, Station A, Mississauga, ON, L5A 2Y9 to:

1. 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 applied only to me, my spouse and my children, identified below:

1. Spouse — Health Insurance Number:
2. Children — Health Insurance Number:
Health Insurance Number:

2. Transmit to, and receive from, the Régie all information and documents required for the assessment and payment of said claims.

3. 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 it 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)

AUTHORIZATION - MEDICAL

The following authorization statements are providing RBC Insurance Company of Canada authorization to obtain, recover and forward information, payments and/or obtain recovery from your Provincial Health Insurance Plan , Extended Health benefits company and/or other sources on your behalf.

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 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.

3. I hereby assign to RBC Insurance Company of Canadaany 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.

Print Name of Claimant/Designated Legal Representative

Signature of Claimant/Designated Legal Representative ***Date***

If claimant is a minor the Parent or Legal Guardian must sign this section on his/her behalf. If a legal representative, other than the patient's legal guardian signs this form, proof of "Legal Representative status" is required i.e. (Power of Attorney, Will, etc.). A copy of this authorization shall have the same authority as the original.