# EMERGENCY MEDICAL EXPENSE CLAIM FORM

**Please complete, sign and return promptly to Allianz Global Assistance.**
**Without this information, we are unable to proceed with your claim.**

**P.O. Box 277** **or** **P.O. Box 71987**
**Waterloo, Ontario** **Richmond, VA USA**
**N2J 4A4** **23255-1987**

## PATIENT INFORMATION

**Policyholder Information (if different from patient)** Case:______ - ________________

Policyholder Name: _________________________________ Policy No.: _________________________ Certificate No.:_______________________

Policyholder's Date of Birth: _________________________ (MM/DD/YYYY) Patient's Relationship to Policyholder: ______________________

Patient Name:________________________________________ Patient's Date of Birth: ___________________ Male ☐ Female ☐

Address: _____________________________________________ City: ________________ Province: ___________ Postal Code:__________

E-mail: __________________________________ Can we contact you via Phone / E-mail? (circle preference)

Patient's Provincial Health Card Number: _______________________________ version code (for some Ontario residents) ________________

Have you paid for treatment? ☐ No ☐ Yes Total amount being claimed: $________________________

**Please specify service provider name, amount paid and currency of payment. If you have additional expenses please attach an additional page.**

☐ Partial or Paid in Full (submit proof of payment ) Service provider name:______________________________ Amount Pd:__________

☐ Partial or Paid in Full (submit proof of payment) Service provider name:________________________________ Amount Pd:__________

## TRAVEL DETAILS

Departure Date: ___________________ (MM/DD/YYYY) Anticipated/Scheduled Date of Return: ___________________ (MM/DD/YYYY) Actual Return Date: __________________ (MM/DD/YYYY)

Nature of Travel:☐ Business ☐Vacation ☐ Study ☐ Medical Care ☐ Other: ________________ Destination: _____________________________

Mode of Travel:☐ Car ☐ Airplane ☐ Other: ____________ If applicable, was Extension of Coverage purchased? ☐ No ☐ Yes (specify)

## OTHER INSURANCE INFORMATION FOR COORDINATION OF BENEFITS

**Employer Information**
**If retired, specify name of employer providing benefits:**

Spouse's Name:______________________________________________
Spouse's Date of Birth: _______________________ (MM/DD/YYYY)

Employer Name: ___________________________________ Retired? ☐ Spouse's Employer: _____________________________ Retired? ☐

Address: ______________________________________________ Address: ______________________________________________

Phone: ___________________________________________ Phone: ___________________________________________

**Please indicate all other insurance coverage you have through any other insurer: (i.e. employee/retiree/spousal group benefits, credit cards with insurance benefits, or any other purchased travel plan). Attach an additional page if required.**

1) Name of Insurer: ______________________________________________ Phone: ___________________________________________

Address: _______________________________________________ Lifetime payable limit on policy? ☐ No ☐Yes (specify) $__________

Policy No: _________________ Certificate No: ______________________ Signature of Policyholder: ____________________________________

2)Name of Insurer: ______________________________________________ Phone: ___________________________________________

Address: _______________________________________________ Lifetime payable limit on policy? ☐ No ☐ Yes (specify) $__________

Policy No: _________________ Certificate No: ______________________ Signature of Policyholder: ____________________________________

Credit Card Insurance coverage: include card type and bank: _____________________________ Number:_________________________________

Have you submitted these bills to any of the above insurance companies? No Yes If yes, which company? ___________________________

**SEE REVERSE FOR PAGE 2**

## MEDICAL INFORMATION

Please describe briefly, the situation leading you to seek medical attention, including the diagnosis.

________________________________________________________________________

________________________________________________________________________

Were medical services required as result of an accident? Yes No If "Yes", please provide details and include an accident report with this form.

________________________________________________________________________

________________________________________________________________________

Name of Hospital: ________________________________________ Date of Occurrence: ______________________

## AUTHORIZATION

### SPECIAL DIRECTION FOR GOVERNMENT HEALTH INSURANCE PLAN AND OTHER INSURANCE COVERAGE

I understand that AZGA Service Canada Inc.*, doing business as Allianz Global Assistance ("Allianz Global Assistance") is acting on behalf of Sun Life Assurance Company of Canada* ("Sun Life").

I direct and authorize my provincial government health insurance plan (GHIP), including OHIP, to make a payment in respect of my claim for out-of-country medical emergency services to Allianz Global Assistance directly. I hereby release GHIP, upon payment to Allianz Global Assistance, from any further claim or cause of action in connection with this claim. For those provinces, having plans that do not allow third party assignment of benefits, I agree to reimburse Allianz Global Assistance the full amount received by me from the provincial plan and to provide Allianz Global Assistance with all necessary, relevant and applicable documentation from the provincial plan concerning any payments or denials of claims.

In consideration of payment made on my behalf, I authorize any benefits paid or payable by any other insurance carrier in respect to this claim, to be assigned in whole or in part to Allianz Global Assistance.

### CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that I have completed this claim form and that the answers given on Page 1 and Page 2 are complete, current and accurate to the best of my knowledge and belief.

I authorize Allianz Global Assistance to collect, use and disclose my personal information, including credit card information and information concerning my medical emergency, including my medical history, symptoms, treatment, examination or diagnoses to each other and any party including any physician, hospital or other health professionals, institutions, GHIP, investigative agencies, insurers and reinsurers for the purposes of determining any insurance coverage relevant to the adjudication of my claim for out-of-country health services, administration purposes, and underwriting purpose.

I understand that if I am a dependent under this insurance coverage, the named insured will have access to all information related to this claim.

In the event there is suspicion of fraud or abuse concerning my claim, I acknowledge and agree that Allianz Global Assistance and/or Sun Life may disclose information about me pertaining to this claim, to any relevant organization including regulatory bodies, government organizations, other insurers, and my Plan Sponsor for the purposes of the investigation, detection and prevention of fraud or abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me under my benefits plan(s), and the collection, use and disclosure of information about this claim to other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor for that purpose.

I understand that I may withhold my consent to the collection, use, and disclosure of such information; however, if I do so my claim cannot be processed and paid. I agree that a photocopy or facsimile of this authorization shall be as valid as the original and that this authorization shall be considered valid for the duration of this claim. I understand information about me may be reviewed in the event that this plan is audited.

Name of Patient (Please print): ____________________________________ Date: ____________________ MM/DD/YYYY

Canadian Address: ____________________________________________________________

Signature of **Patient / Designated Legal Proxy** **: ________________________________ Phone No: ____________________

Signature of **Policy Holder**: ____________________________________ Date: ____________________ MM/DD/YYYY

* Any reference to AZGA Service Canada Inc. or Sun Life Assurance Company of Canada includes their respective agents, service providers and, where applicable, reinsurers.

** If the patient is a minor, his/her legal guardian must sign on his/her behalf. If a legal representative other than the patient's legal guardian signs this form, (power of attorney, executor/executrix etc.) the provincial health plan requires proof of "Legal Representative" status.

**When sending original documents, be sure to keep a copy for your records.**
**If you have questions, please call us at 1-800-363-1835. Our Customer Service Team can help.**

If you would like to know more about the Allianz Global Assistance Privacy policy please visit: www.allianz-assistance.ca/en/legal-information.aspx and for Sun Life's Privacy policy please visit: www.sunlife.ca/privacy