MRM Special Risks Inc.

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Telephone #: (514) 875-5005
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POLICY # SRG 912 5975

EXPATRIATE HEALTH INSURANCE CLAIM FORM

Policy ID No. (5 digits):	EMAIL Address:	Case #:
Insured's Surname:	Insured's Given Name: ___ M ___ F	Insured's Date of Birth: D ____ M ____ Y____

Residence Address.:

Apt./Unit No.: City/Town: Province: Postal Code:

Telephone No.:

REIMBURSEMENT: ***(All reimbursements will be mailed to the above address.)***

☐ I wish to be reimbursed by direct deposit in Canadian funds. *(I have attached a voided cheque from my Canadian bank account).*
☐ I wish to be reimbursed by cheque: ☐ In Canadian dollars ☐ In US dollars
☐ I wish to be reimbursed by a bank transfer in ____________ Currency. If not available the bank transfer will be issued in US dollars. *(I have attached my bank account information)*

Please note, we are not responsible for any fees charged by your Financial Institution pertaining to Bank Transfers or cashing Cheques.

Note: You will receive a payment once the total of your reimbursements amount to $50.

Patient's Name: ☐ M ☐ F

Patient's Date of Birth: D _______ M_______ Y_________	Relationship to Insured:
Total Amount of this claim: $ ____________________________	Patient's Provincial Health Insurance Card No. and Verification Code:

Out of Province/Country Temporary Address: ______________________________________

1. Departure Date: Return Date: Destination:
2. Mode of Transportation: Reason for Trip:
3. Name and Address of Family Physician:
4. Name and Address of first Physician consulted:

5. Date of initial onset of illness or injury: D _______ M_______ Y_________

Date of Previous Occurrence or Treatment: D _______ M_______ Y_________

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6. **Diagnosis**: ____

Provide a brief description of the illness/injury which required treatment outside your Province/Country?________________________

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7. If hospitalized, advise date of admission: ___________________________________Discharge Date:___________________________

Name of Hospital:____

Address:____

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8. If illness, has the patient had this or similar illness before: ( ) Yes ( ) No

If yes, give dates, name/address of physician: ____

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9. Was the current treatment due to an emergency? ( ) Yes ( ) No

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10. Was the patient advised to seek treatment for this condition in a place other than their normal province of residence? ( ) Yes ( ) No

If Yes, please explain____

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11. Name and address of Employer:____

Employer Phone Number:____

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12. Name of Insurance Company who carries your Group Hospital/Medical Insurance or Extended Health Plan: __________________

OTHER INSURANCE:

13. Do you carry any other excess Hospital/Medical or Travel Insurance: ( ) Yes ( ) No

If Yes, Name of Company____ Telephone #: ______________________________

Policy #: ____ Certificate #: ____

14. Do you have a premium credit card (GOLD CARD) which provides out-of-province/country medical coverage? If yes, provide details:

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15. If injuries are the result of an automobile accident, advise name of Insurance Company:_____________________________________

Policy Number:____ Claim Number:______________________________________

Name/Address of Insured, if other than yourself: ____

PLEASE LIST EACH RECEIPT, PROVIDE ALL INFORMATION AS REQUESTED AND ATTACH ORIGINAL RECEIPTS.
If you are claiming for surgery or hospitalization, please include supporting medical documentation from the attending physician specifying the reason why the services claimed were medically necessary.

MEDICAL EXPENSES

Patient's Name	Date of Service	Amount	Currency	Type of Service Name of Prescription Drug	Reason for Treatment Reason for Prescription Drug
	Total:				

PERSONAL INFORMATION NOTICE: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by AIG Insurance Company of Canada (the "Insurer"), its reinsurers and authorized administrators; Globe Insurance Management Co. Inc. to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties.
CERTIFICATION: The statements I provide in completing this claim form and otherwise in respect of my claims are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.
AUTHORIZATION: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with AIG Insurance Company of Canada and authorized administrator, Globe Insurance Management Co. Inc., thereof, all personal health information and benefit payment information about me or any other information or records about me in its possession that is requested while administering my claim.

I agree that a reproduction of this authorization shall be as valid as the original. I authorize AIG Insurance Company of Canada and Globe Insurance Management Co. Inc. to make payment directly to the service providers when necessary.

YOUR CLAIM IS COMPLETE ONLY IF THE FOLLOWING IS SIGNED AND DATED.

I agree to reimburse to AIG Insurance Company of Canada and/or authorized administrator, Globe Insurance Management Co. Inc. the amounts reimbursed to me on behalf of my provincial health insurance plan, or any other insurance plan who has made payment towards costs of services that have been paid, on my behalf, by AIG Insurance Company of Canada and/or Globe Insurance Management Co. Inc. All refunds will be made payable to AIG Insurance Company of Canada and/or authorized administrator, Globe Insurance Management Co. Inc. by cheque or money order and shall be remitted within 30 days of receipt. **I also authorize the Provincial Plans to refund Globe Insurance Management Co. Inc. all amounts which would have been paid to me.**

Signed____ **Dated**______________________________

PLEASE REMEMBER TO ATTACH ALL ORIGINAL RECEIPTS AND PROOF OF PAYMENT.
Claims must be submitted within 90 days of the end of the calendar year in which expenses were incurred but no later than 90 days following your termination date.

MAIL TO: Globe Insurance Management Company Inc., 1100 René-Lévesque Blvd. West, Suite #1100, Montreal, QC, Canada H3B 4N4