Globe
Société de gestion en assurances Globe inc.
Globe Insurance Management Company Inc.
Email: service@globeassurances.com
Telephone #: (514) 875-5005
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MRM Special Risks Inc.

POLICY # SRG 912 7213

VISITORS TO CANADA – EMERGENCY MEDICAL CLAIM FORM

No Provincial Plan Coverage

Policy ID No. (5 or 6 digits):	EMAIL Address:	Case #:
Insured's Surname:	Insured's Given Name: ☐ M ☐ F	Insured's Date of Birth: D ___ M ___ Y___

Mailing 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: Day _____ Month_____ Year_____	Relationship to Insured:

Country of Residence Address: _____

1. Departure Date from your Country of Residence: _____ / _____ / _____ Return Date: _____ / _____ / _____
   Destination:_____
2. Mode of Transportation: Reason for Trip:
3. Name and Address of Family Physician in your Country of Residence:
4. Name and Address of first Physician consulted:

5. Date of initial onset of illness or injury: Day _____ Month_____ Year_____

Date of Previous Occurrence or Treatment: Day _____ Month_____ Year_____

6. **Diagnosis**: _____

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

7. If hospitalized, advise date of admission: _____Discharge Date:_____

Name of Hospital:_____

Address:_____

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

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

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

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_____

11. Name and address of Employer *(if applicable)*: _____

Employer Phone Number:_____

12. Name of Insurance Company who carries your Group Hospital/Medical Insurance or Extended Health Plan *(if applicable)*: _____

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:

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

Policy Number:_____ Claim Number:_____

Insurance Company's Telephone #: _____

Name, Telephone No. and 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 (medical report) specifying the reason why the services claimed were medically necessary.

EMERGENCY 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 from the service date 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

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

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AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT

Dear Sir or Madam:

I, the undersigned, _____ 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 its 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. **Otherwise, I authorize, Globe Insurance Management Co. Inc., to mail and issue the payment of my claim via a Canadian or US cheque, payable to the order of:**

Name: _____ **Relationship:** _____

Mailing Address: _____

_____

☐ **Canadian Cheque** ☐ **US Cheque**

Direct Deposit Authorization:

Or, I hereby authorize Globe Insurance Management Company Inc. to credit my claim payments in Canadian dollars to the bank account identified below. This authorization may be cancelled at any time upon written notice by me.

Please attach a cheque marked "VOID" to this Authorization Form. The cheque must be for the account in which you would like the claim payments deposited.

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.

Insured person's Signature: _____ **Date:** _____