## **AUTHORIZATION, CONSENT AND RELEASE FOR RESIDENTS OF ONTARIO**

	n and Release
services to Old release OHIP,	irrevocably direct and authorize the Ontario Ministry of ng-Term Care ("the Ministry") to make payment in respect of my claim for out-of-country health Republic Insurance Company of Canada/Reliable Life Insurance Company directly and I hereby upon payment to Old Republic Insurance Company of Canada/Reliable Life Insurance Company or claim or cause of action in connection therewith.
2. Consent	
I authorize the	Ministry to collect my personal health information, consisting of: ion relating to my receipt of health care services outside of Canada, ion relevant to the reimbursement of those services under the Health se Act, R.S.O. 1990, c. H.6
to disclose suc payment under	ablic Insurance Company of Canada/Reliable Life Insurance Company, and authorize the Ministry of personal health information as may be required for the purpose of verifying my request for the Health Insurance Act, including the details of any duplicate payment previously made to me, or Insurance Company of Canada/Reliable Life Insurance Company.
	e purpose for the Ministry's collection and disclosure of this personal health information. at I can refuse to sign this consent form.
about the Insurinformation the reimbur from Old Repute disclose such	consent on behalf of a person who is not capable of consenting to the collection, use and bersonal health information:
	the Health Insurance Act, including the details of any duplicate payment previously made to me, to nsurance Company of Canada/Reliable Life Insurance Company.
	e purpose for the Ministry's collection and disclosure of this personal health information. at I can refuse to sign this consent form.
	itute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to all health information about the individual.
3. Authoriz My Name:	wation Witness Name:
Home Tel:	Home Tel:
Work Tel:	Work Tel:
Address:	Address:
Signature:	Signature:
Date:	Date:

## Claims Administration OLD REPUBLIC INSURANCE COMPANY OF CANADA RELIABLE LIFE INSURANCE COMPANY

Box 557, 100 King Street West Hamilton, Ontario L8N 3K9 **Toll Free**: 888.831.2222 **Fax**: 866.551.1704

## EMERGENCY MEDICAL CLAIM FORM

**Please Note:** Benefits under any coverage will not be paid for expenses reimbursed or services provided by any other source.

Benefits cannot be duplicated under this Protection Plan.

## PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF THE OCCURRENCE

Part I	Part I GENERAL INFORMATION					
Claimant's Name (Last, First)	GENERAL					
Ciaimant 5 Name (Last, First)		Policy No.	Date Of Diffi			
Full Address						
Home Phone No.	Business Phone No.	Government Health Insurance No.	Version Code			
Tour Operator's Name						
Travel Agency's Name		Travel Agent's Name	Telephone No.			
Travel Agency's Full Address		L	1			
Date Initial Deposit Paid for Trip	Departure Date	Scheduled Return Date	Actual Return Date			
(MM / DD / YY)	( MM / DD / YY )	(MM / DD / YY)	( MM / DD / YY )			
Departure City		Destination (City, Country)				
Part II	EVDI ANA	TION OF LOSS				
Describe fully the circumstances of the	e sickness or injury					
Date of onset of sickness or injury	Location (City, Country)					
( MM / DD / YY )  Date of first consultation	Name of Dhysician who treated you		Ware you be enitedized?			
Date of first consultation	Name of Physician who treated you		Were you hospitalized?  ☐ Yes ☐ No			
( MM / DD / YY )			- 162 - 140			
If yes, name of hospital		Admission date	Discharge date			
		(MM / DD / YY)	(MM / DD / YY)			
Did you contact the Assistance Provider?	If yes, date contact was made	Have you ever had the same or similar condition?	If yes, when did the condition occur?			
☐ Yes ☐ No	(MM / DD / YY)	☐ Yes ☐ No	(MM / DD / YY)			
Were you prescribed medication?	Were the prescriptions/dosages changed prior to trip departure?	If Yes, please indicate the date	Name of Family Physician			
☐ Yes ☐ No	☐ Yes ☐ No	( MM / DD / YY )				
Full address of Family Physician	·		Telephone No.			

Part III			MEDICA	L EXPENSES				
Name of Medical Service Provider/Doctor	Date of Service (MM / DD / YY)	Amount on Invoice (IN CDN \$)	Did you pay this invoice?	Name of other Health Insurance Company/Plan Invoice submitted to  Amount paid by other Insurance Company/Plan Company/Plan			Amount claimed (IN CDN \$)	
_	If you hav	e more expenses	nlease provide a bro	eakdown on an additional sl		Claimed in CDN \$		
Part IV	li you nave	s more experience,	-	COVERAGE	neer using the a	DOVE TOTTILAL		
	other Health Insurance	e coverage/plans?	UIHER	COVERAGE				
	ue Cross, Work Place/	٠.	· · · · · · · · · · · · · · · · · · ·	Yes No  EASE COMPLETE:				
1) Name of Insuran	nce Company	Pc	Policy No. Telephone			lo.		
Address of Insurance	ce Company							
2) Name of Insuran	nce Company	Pc	Policy No.		Telephone No.			
Address of Insuran	ce Company				.1			
Was your medical e		Name of the Third Party						
☐ Yes ☐ ☐		Full address of the Third Party						
Third Party was responsible?		Contact No. of the Third Party						
IMPORTANT	– PLEASE ENCL	OSE ORIGINAL	RECEIPTS FOR #	ALL MEDICAL EXPENSE				
				COMPANY, PLEASE P PONSIBILITY" INVOICES				
I/We authorize a payment in resp authorize Old R	any other insurand pect of my/our clai Republic Insurance	ce plan, under w im to Old Repub e Company of Ca	which I/We have co blic Insurance Com anada/Reliable Lif	PLETE AND CORRECT. coverage, to disclose infompany of Canada/Reliablife Insurance Company to respect to my/our claim.	ormation as ma le Life Insurand o disclose to a	ce Company directly	/. I/We also	
Signature of Insured/Claimant				_	Date	(MM/DD/	YY)	
Signature of Insure	ed/Claimant				Date	(MM/DD/	YY)	

Part V	PATIENT CONSENT TO DISC	CLOSE HEALTH INFOR	MATION	
Patient's full name at time	of treatment:			
Date of birth: (MM/DD/YY) _	111			
	DICATION OF TRAVEL INSURANCE			
·				
	ce Coverage: (MM/DD/YY)			
Medical Facilities: (List all	doctors consulted for this condition an	d hospitals where confined)		
Name	Address	Telephone No.	Fax No.	Dates
				11
				11
				11
You are authorized to give	re Old Republic Insurance Compar			
<u> </u>	ting agency, or independent claims	•		
=	rance Company, any information cond	<del>-</del>	· · · · · · · · · · · · · · · · · · ·	
other information that may	have bearing on the request for benef	fits submitted in conjunction wi	th the travel insuranc	e policy.
Information to be released	:			
	e Patient for up to 5 years before th		=	
=	consent as shown below as appl		=	
	n, diagnosis list, medication list, phy		physical therapy re	ecords, occupational therapy
records, pathology reports	, cytology reports and the results of all			
	Send to: Travel Claims I	Department 100 King St. W.		
	Hamilton, ON L	=		
	Telephone: 1-8	888-831-2222 Fax: (905) 528-	3338	
By signing below, I unde	erstand that:			
•	nealth record may include information	,	•	•
syndrome (AIDS), or hi	uman immunodeficiency virus (HIV). It	may also include information a	bout behavioral or m	ental health
	t for alcohol and drug abuse.			
=	ke this consent at any time by providing		-	ords are kept.
·	ply to information that has already bee	·		
<ol> <li>A revocation will not ap my policy.</li> </ol>	ply to my insurance company when th	e law provides my insurer with	the right to contest a	ı claim under
5. Unless otherwise revok	ed, this consent will expire in six mont	ths.		
6. Consenting to the discl	osure of this health information is volu	ntary. I can refuse to sign this	consent.	
7. Any disclosure of inforr	nation carries with it the potential for a	ny unauthorized re-disclosure	and the information m	nay not be
protected by federal co	nfidentiality rules.			
Lauthorize Old Republic Ir	nsurance Company of Canada/Reliable	a Life Insurance Company to d	isclose my health or d	claim information to any
•	e, tour operator, travel suppliers, etc.)	· · ·	-	-
· -	settled. I hereby assign to Old Repub		-	-
	ained from these sources for losses co			
	any of Canada/Reliable Life Insurance			That a form barbonnes in to Gra
Signature of patient or aut	horized person:		Date: (MM/DD/YY)	1 1
			, ,	
Relationship/Reason patie	nt is unable to sign:			