CLAIM FORM

Submit Claims to:
SelectCare Worldwide Claims Department
2100 – 250 Yonge Street
Toronto, Ontario, Canada M5B 2L7
Phone: 1-866-261-4441
Fax: 416-340-7152

INSTRUCTIONS

IMPORTANT

- In the event of hospitalization, SelectCare Worldwide® (SCW) must be notified prior to, or within 24 hours of admission to hospital, and prior to any surgery or invasive investigations being performed.
- All claims must be reported within 30 days of occurrence.
- Written proof of claim must be submitted within 90 days of occurrence.
- You are responsible for any fees charged for completing this form or issuing supporting documentation.
- This form must be completed by the insured, or if a minor, by the legal guardian or parent.

REQUIREMENTS

- Completed and signed claim form.
- Claim form must be completed by a parent or legal guardian if the insured is a minor.
- All original bills and/or receipts. Photocopies will not be accepted.
- All bills must be itemized and show dates and costs of all treatment received.
- For Multi-trip Plans, include proof of original departure from and return to your province or territory of residence, such as airline tickets, customs stamp, or other evidence acceptable to SCW.
- Please refer to the claims procedures in the policy booklet or your agent for details on what is required to substantiate your claim.

SECTION A: CLAIMANT INFORMATION

1. Insured's First Name: _____ Last Name: _____

❑ Male ❑ Female Date of Birth: MM/DD/YYYY Policy #: _____

Telephone: ( ) Fax: ( ) Email: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Destination: _____ Departure Date: MM/DD/YYYY Return Date: MM/DD/YYYY

SECTION B: MEDICAL INFORMATION

1. If your claim is due to sickness, when did symptoms first appear? MM/DD/YYYY Date of first treatment: MM/DD/YYYY
2. What is the diagnosis? _____
3. Have you experienced this sickness or a similar problem before? ❑ Yes ❑ No If 'Yes', when? MM/DD/YYYY

Treating Doctor's Name: _____ Telephone: ( )

Name of usual pharmacy: _____ Telephone: ( )

Please provide the names of any medications you were taking prior to visiting the doctor: _____

4. Do you have any chronic sickness or disease? ❑ Yes ❑ No If 'Yes', please provide date diagnosed and describe condition/diagnosis:

Date: MM/DD/YYYY Diagnosis: _____

Name and Address of usual Family Physician Name: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____ Telephone: ( ) Fax: ( )

5. Was the condition related to pregnancy? ❑ Yes ❑ No If 'Yes', date of last menstrual period: MM/DD/YYYY Expected delivery date: MM/DD/YYYY
6. Was the condition related to the use of alcohol, misuse of drugs, or self-inflicted injury? ❑ Yes ❑ No

If 'Yes', please provide details: _____

7. In the case of an injury, how, when and where did it happen? _____
8. **Please provide the following information if your claim relates to a motor vehicle accident**

Name and Address of Auto Insurance Company Name: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____ Telephone: ( )

Policy number with auto insurance company: _____

SECTION C: EXPENSES CLAIMED

Amounts paid by you will be reimbursed to you if claim is eligible. Otherwise amounts will be paid directly to the provider of service. You are financially responsible for the expenses not covered by your insurance.

Name of Service Provider (for example: doctors, hospital, clinic)	Date of Service	Amount Billed	Amount You Paid
1.	MM/DD/YYYY		
2.	MM/DD/YYYY		
3.	MM/DD/YYYY		
4.	MM/DD/YYYY		

SelectCare® WORLDWIDE

SECTION D: PROVINCIAL GOVERNMENT HEALTH INSURANCE (GHIP) AUTHORIZATION AND ASSIGNMENT

Residents of Alberta, Saskatchewan, Ontario, Nova Scotia, PEI, New Brunswick, Manitoba and all territories must complete this form in full. Residents of BC, Quebec, and Newfoundland must complete additional forms.

I agree that, according to the terms of this policy and in respect of my applicable provincial government health insurance (GHIP) legislation pertaining to freedom of information and protection of privacy; and in consideration of any monies SelectCare Worldwide (SCW) may advance to me as a result of the issuance of this policy, I hereby irrevocably:

1) Direct and authorize GHIP to make payment in respect to my claim for out-of-country health services to SCW directly and I hereby release GHIP, upon payment to SCW, from any further claim or cause of action in connection herewith; and
2) Consent and authorize GHIP to directly or indirectly collect information contained in the claim and source document pursuant to Section 39(1) of the Freedom of Information and Protection of Privacy Act, and Section 4(2)(f) of the Health Insurance Act in Ontario only, and
3) Consent and authorize GHIP to furnish to any representative of SCW such records and information as may be required for the processing of my claim for out-of-country health services, including the details of any duplicate payment previously made directly to me.

Insured's Signature: _____ Date: MM/DD/YYYY _____ GHIP #: _____

Witness Signature: _____ Date: MM/DD/YYYY _____ Version Code: _____
(Ontario Residents only)

SECTION E: OTHER INSURANCE COVERAGE (If the insured is a minor, this section is applicable to a parent or legal guardian)

Do you have any other travel or out-of-country medical insurance coverage through your employer, your spouse's employer or a retiree plan?
❑ Yes ❑ No If 'Yes', provide details below.

Plan	Name of Insurance Company	Group Policy #	Member ID#	Telephone
Your Employer				( )
Your Spouse's Employer				( )
Retiree Plan				( )

Name of Spouse: _____ Spouse's Date of Birth: MM/DD/YYYY

Do you have insurance benefits available through homeowner's insurance, automobile insurance or any other source?
❑ Yes ❑ No If 'Yes', provide details below.

Plan	Name of Insurance Company	Policy #	Telephone
Homeowners Insurance			( )
Automobile Insurance			( )
Other			( )

Do you have credit card insurance coverage for travel outside your province? ❑ Yes ❑ No

Name and address of issuing bank for credit card Name: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

First 6 digits of credit card #: _____ Expiry Date: MM/YY

Name of Cardholder (please print): _____ Cardholder Signature: _____
(if different from insured)

Insured's Signature: _____ Date: MM/DD/YYYY

SECTION F: AUTHORIZATION AND CERTIFICATION

SelectCare Worldwide® (SCW) is committed to protecting the privacy, confidentiality and security of the personal information we collect, use and disclose. Your personal information will be used only for the purpose of providing you with the requested insurance services. For a copy of SCW's privacy policy, please contact us.

I authorize any doctor, hospital, pharmacy or facility providing medical or health-related services, and any other insurer to release and exchange with SCW or its representatives, any information that is required to process this claim. I assign to SCW any benefits payable from any other sources for losses covered under this policy, and I authorize and direct such payors to forward payment directly to SCW. I also authorize any third party providing me with assistance in this claims process, to have access to any and all relevant claims information related to the adjudication of my claim with SCW. I confirm I am authorized to act on behalf of my dependants for these purposes. A photocopy of this authorization shall be as valid as the original. I certify that the information provided in connection with this claim is complete, true and accurate.

Full Name of Patient/Insured (please print): _____ Date: MM/DD/YYYY

I authorize payment of this claim to (print name): _____

Signature of Insured (if minor, signature of parent or legal guardian): _____

Signature of policyholder of other insurance in Section E (if applicable): _____

SelectCare® WORLDWIDE