G | m | S

TRAVEL EMERGENCY MEDICAL
Claim Form

Saskatchewan residents with travel medical claims incurred within or outside Canada sign and date the completed form and return the package to:

Group Medical Services
2055 Albert Street PO Box 1949
Regina, SK S4P 0E3 CANADA

For claims inquiries, please contact toll free 1.800.667.3699 (within Canada and the USA) or collect 306.352.7638.

Residents of other Canadian Provinces/ Territories sign and date the completed form and return the package to one of the following addresses:

Travel claims incurred **within** Canada
Group Medical Services
2055 Albert Street PO Box 1949
Regina, SK CANADA S4P 0E3

Travel claims incurred **outside** Canada
Allianz Global Assistance
PO Box 277
Waterloo, ON CANADA N2J 4A4

For claims inquiries, please contact toll free 1.800.459.6604 (within Canada and the USA) or collect 905.762.5196.

Please attach the following documents:

- ☐ All original itemized medical bills and prescription receipts
- ☐ A photocopy of the sick/injured person's provincial health card
- ☐ Documentation confirming your departure and return dates (i.e. airline tickets, gas receipts, etc.)
- ☐ In the event that you have paid any eligible medical expenses, please provide proof of payment (i.e. credit card vouchers, cancelled cheques, etc.)
- ☐ In the event you paid for expenses in a different currency, please provide your credit card statement

A. Personal Information

First Name	Last Name	Date of Birth *(DD/MM/YYYY)*	
Destination Address	City	Province/State	Postal/Zip Code
Destination Phone ( )	Home Phone ( )		
Home Address	City	Province	Postal Code
GMS Policy #	Email		

B. Insured Details

Name of Ill or Injured Person	
Provincial Health Plan Number of Claimant	Version Code (ON Residents Only)
Departure Date *(DD/MM/YYYY)**	Return Date *(DD/MM/YYYY)**

**** Please attach documents confirming these dates***

C. Claim Details

Nature of Sickness or Injury	Date of Incident *(DD/MM/YYYY)*
Describe how the incident occurred.	

Have you paid any invoices?
☐ Yes ☐ No *If yes, provide amount paid $* _____ *Currency Type*_____

Please list the name, address, and phone number of all physicians and specialists the claimant saw before the departure date.

Name & Specialty	Address	Phone Number
		( )
		( )
		( )

Did the patient suffer symptoms, receive medical advice, treatment, investigation and/or was medication prescribed or changed for this medical condition
❑ 90 Days ❑ 180 Days ❑ 365 Days Immediately before departure? ❑ Yes ❑ No

If yes, please describe:

D. GMS Policy Information

Which GMS policy do you have? *(check all that apply)*

❑ TravelStar® Single-Trip Emergency Medical ❑ TravelStar Multi-Trip Annual Emergency Medical ❑ StudentPlan

❑ Personal Health Annual Travel ❑ Replacement Health Annual Travel

❑ Group *Name of Group* _____ *Policy/ID #* _____

E. Other Insurance Coverage *(If the insured is a child, this section is applicable to the parent or legal guardian)*

This insurance pays eligible expenses in excess of those covered by any other insurance. Therefore, if at the time of loss you have similar coverage with another provider (e.g. credit card, travel insurer, employment group health plan, private or provincial auto plan, etc.), benefits will be coordinated in accordance with the Canadian Life and Health Insurance Assurance guidelines.

Do you and your spouse or child have other travel insurance benefits? ❑ Yes ❑ No ** Please provide details (attach additional information if necessary)*

Type of Plan	Policy/ID/Credit Card #

Name and Address of Bank/Credit Card or Insurance Company

☐ I hereby warrant that I do not have any other travel or out-of-province medical insurance coverage *(check if applicable).*

F. Certification and Authorization

The insurer, its administrator, Allianz Global Assistance and their agents, are obliged to collect and retain certain personal and/or health information about you in connection with your insurance coverage. They use and disclose that information only for the purposes of administering your policy/policies of insurance, providing customer service, and assessing and paying claims.

- I/We authorize any licensed physician, medical practitioner, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, provincial health insurance plan and employer(s) to provide the Insurer, its administrator, Allianz Global Assistance and their agents engaged to assist in the administration of this claim, any information, including personal information, data, or records that are in their possession/knowledge, regarding my medical history and treatment.
- I/We direct and authorize my government health insurance plan (GHIP) to make payment in respect of my claim for out-of-country health services to the Insurer or its administrator Allianz Global Assistance directly and I hereby release the GHIP, upon payment to the Insurer from any further claim or cause of action in connection herewith.
- I/We hereby consent and authorize the GHIP to directly or indirectly collect information contained in the claim and source documents pursuant to the Freedom of Information and Protection of Privacy Act and the Health Information Protection Act.
- I/We authorize the Insurer and its administrator, Allianz Global Assistance, to coordinate the payment of benefits with any other insurance carriers which may also have a liability for this claim.
- I/We hereby irrevocably authorize the Insurer and its administrator, Allianz Global Assistance, to make any payments, receive payments, and settle with any carriers on my behalf.

I hereby consent to the collection, use and disclosure by the insurer, its agents and administrators of the personal and health information about me disclosed herein and in all documents or information provided in connection with my policy/policies of insurance for the purposes cited above.

If the undersigned is signing on behalf of any person(s), the undersigned represents to having the authority to sign on behalf of such person(s) and confirms that each of the above declarations and authorizations are also provided on behalf of such person(s).

A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from date signed.

Signature of Claimant/Guardian/Executor	Claimant/Guardian/Executor *(please print)*	Date *(DD/MM/YYYY)*
X		

What to Expect During the Claims Process

If you have contacted the GMS emergency assistance centre, we will have arranged to have all bills sent directly to Group Medical Services. Once eligibility and payability are determined, the approved payments will be sent directly to the facilities and/or health providers.

It is our goal to process eligible claims in a prompt manner, however, processing may be delayed for the following reasons:

- Delay in the receipt of mail from providers billing direct
- Delay in receipt of medical information from your treating or family physician
- Incomplete claim form and/or insufficient supporting documentation

Due to variations in health billing systems between countries, you may receive invoices or reminder notices directly from the health provider. Should you receive any such correspondence or if you have paid invoices directly, please forward these to the address indicated above.

We request that you should not pay any medical accounts directly to the providers unless you have been advised to do so by Group Medical Services.

In order to expedite your claim, please return the completed claim form and all supporting documents as soon as possible. Failure to complete the claim form and attach requested documents will delay the processing of your claim. Please keep a copy of all submitted correspondence for your records.