Hospital & Medical

How to Submit a Claim

Allianz
Global Assistance

TO SUBMIT YOUR CLAIM:

STEP 1 Gather all your claim documentation
STEP 2 Complete and sign the claim form
STEP 3 Complete any other necessary forms
STEP 4 Complete the checklist below
STEP 5 Mail all documentation to Allianz Global Assistance

IMPORTANT

- 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.

CHECKLIST

Do you have:

❑ The fully completed claim form, signed and dated?
Incomplete claim forms will be returned to you and this will delay the processing of your claim submission.

❑ All original receipts?
Photocopies will not be accepted.

❑ For Multi-trip/Annual plans: Proof of departure?
For example: boarding pass; plane ticket; copy of stamped passport; if driving, credit or debit card statement showing purchases ***before*** *leaving province and* ***after*** *arriving at destination.*

❑ Provincial forms, if required?

Province	Form(s)
Alberta	Insurance claim consent and authorization
British Columbia	Schedule A Out-of-Country Claim Form
Saskatchewan	Schedule A and Schedule B
Ontario	OHIP Authorization and Release Form
Quebec	Application for Reimbursement Power of Attorney
Newfoundland and Labrador	Out-of-Province Claim Form Application for Newfoundland Hospital Insurance Benefits
Nova Scotia, PEI, New Brunswick, Manitoba, all Territories	No provincial forms required

❑ A copy of all documents for your records?

Send your completed forms and original receipts to:

Allianz Global Assistance Claims Department
250 Yonge Street, Suite 2100
Toronto, Ontario M5B 2L7
Canada

To check your claim status, please call:

Toll-free Canada/USA: 1-800-869-6747
Collect worldwide: 416-340-8809
E-mail: claims.to@allianz-assistance.ca

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SECTION 1: PRIVACY AND DECLARATION

Allianz Global Assistance Privacy Statement

Allianz Global Assistance is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

At Allianz Global Assistance, we recognize and respect the importance of privacy. When you enrol for insurance coverage or submit a claim, we establish a confidential file and collect, use and disclose your personal information for the purposes of issuing, administering, adjudicating and/or servicing your insurance. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other persons we have authorized who have a need to know it to perform their duties. Our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security extends to the contracts and agreements we sign with external suppliers and service providers. We may store or process your personal information in Canada, the United States or other countries for processing, storage, analysis or disaster recovery and, under applicable law, governments, courts, law enforcement or regulatory agencies, may, by lawful order, obtain disclosure of your personal information. You can find more details about Allianz Global Assistance's privacy policy at www.allianz-assistance.ca. If you have any questions regarding our privacy practices, please contact the Privacy Officer at :

AZGA Service Canada Inc.
o/a Allianz Global Assistance
250 Yonge Street, Suite 2100
Toronto, Ontario M5B 2L7
Canada

Telephone: 416-340-1980
E-Mail: privacy@allianz-assistance.ca

If you do not agree with our use and disclosure of your information in connection with your application and servicing any policy that we issue, we will not be able to offer you the insurance product you are interested in, service your insurance or adjudicate your claim.

I have read and understood the privacy statement and I consent to the collection, use, retention and disclosure of my personal information or those of my dependants for the purposes stated above. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated.

I hereby assign to AZGA Service Canada Inc. o/a Allianz Global Assistance any benefits obtainable from other sources for losses covered under this policy. I authorize and direct these sources to release payments to Allianz Global Assistance and for Allianz Global Assistance to release pertinent payments to other parties for the purposes of processing my claim.

I certify that the information contained herein is true, complete and accurate and that each of the listed expenses was purchased and/or incurred in connection with the medical treatment of the individual(s) named below. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning this claim, I acknowledge and agree that Allianz Global Assistance may investigate any information about me, my spouse and/or dependents pertaining to this claim, which may be used and disclosed to any relevant Third Party, and where applicable my plan sponsor, for the purpose of investigating and preventing fraud and/or plan abuse.

If I receive payment from Allianz Global Assistance in an amount that exceeds the benefit(s) to which I am entitled under the policy (the "overpayment amount"), then I acknowledge and agree that: (a) I am indebted to Allianz Global Assistance for such overpayment; (b) Allianz Global Assistance has the right to recover the overpayment amount through any means available by law; and (c) Allianz Global Assistance will offset any benefits payable to me by the overpayment amount until Allianz Global Assistance has recovered the overpayment amount in full.

I declare my statements above, including all other past and future statements made through personal or telephone interviews relating to my claim, to be true, complete, current and accurate.

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

Insured's Name (please print): ______________________ Policy #: ______________________

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SECTION 2: INSURED'S INFORMATION

Insured's First Name: ______ Last Name: ______

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

Phone #: ( ) ______ Cell #: ( ) ______ Fax #: ( ) ______

Email: ______

Address: ______

City: ______ Province: ______ Postal Code: ______

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

SECTION 3: INSURED'S PHYSICIAN INFORMATION

Canadian family physician: ______

Street Address: ______ City: ______

Province: ______ Postal Code: ______ Phone #: ( ) ______ Fax #: ( ) ______

Pharmacy: ______ Phone #: ( ) ______

SECTION 4: MEDICAL INFORMATION

1. What was the diagnosis? ______
2. If your claim is due to **sickness**, when did symptoms first appear? MM / DD / YYYY Date of first treatment: MM / DD / YYYY

   Treating Physician, Clinic, or Hospital: ______

   Have you experienced this sickness or a similar problem before? ❑ Yes ❑ No If 'Yes', when? MM / DD / YYYY

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

   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: ______

   Date: MM / DD / YYYY Diagnosis: ______
3. In the case of an **injury**, when, where and how did it happen? When: MM / DD / YYYY Where: ______

   How: ______

   If injury occurred on private property, please provide the following information:

   Name of company insuring the property: ______ Phone # of insurance company: ( ) ______

   Property owner: ______ Policy #: ______ Claim # (if applicable): ______
4. If your claim relates to a **motor vehicle accident**, please provide the following information:
   (if more than one vehicle was involved, include a separate sheet with the following information for each vehicle)

   Name of company insuring the vehicle: ______ Phone #: ( ) ______

   Vehicle owner: ______ Policy #: ______ Claim # (if applicable): ______

SECTION 5: OUT OF POCKET EXPENSES (original receipts must be provided)

Expense type (for example: physician services, medications, meals, accommodation, taxi)	Date of service	Amount billed	Amount you paid	Currency
1.	MM / DD / YYYY	$	$	
2.	MM / DD / YYYY	$	$	
3.	MM / DD / YYYY	$	$	

Complete the following if another person made the payment for you and you want Allianz Global Assistance to reimburse them directly.

I authorize Allianz Global Assistance to make payment payable to ______ *who has pre-paid my expenses.*

Payment should be sent to Street Address: ______

City: ______ Province: ______ Postal Code: ______

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SECTION 6: OTHER TRAVEL INSURANCE COVERAGE

Do you have any other travel or out-of-country medical insurance coverage?

❑ Yes ❑ No If 'Yes', provide details below.

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

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

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

Name of issuing bank:

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

Name of Cardholder (please print):

Do you have travel insurance benefits available through any other source?

❑ Yes ❑ No If 'Yes', provide details below.

Plan	Name of Insurance Company	Policy #	Telephone
			( )
			( )
			( )
			( )

In consideration of payment made on my behalf, I authorize any benefits paid or payable by any other insurance carrier in respect to this claim, to be assigned in whole or in part to AZGA Service Canada Inc. or, if directed by AZGA Service Canada Inc., to the insurance company underwriting the policy for which such payment was made.

SECTION 7: PROVINCIAL GOVERNMENT HEALTH INSURANCE (GHIP) AUTHORIZATION AND RELEASE

I agree that, pursuant to the terms of this policy and in respect of the applicable provincial health insurance legislation pertaining to freedom of information and protection of privacy; and in consideration for any monies AZGA Service Canada Inc. 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 of my claim for out-of-country health services to AZGA Service Canada Inc. directly and I hereby release GHIP, upon payment to AZGA Service Canada Inc., from any further claim or cause of action in connection therewith;
2. consent and authorize GHIP to directly collect information contained in the claim and source documents pursuant to Section 39 (1) of the Freedom of Information and Privacy Act, and for Ontario Residents pursuant to the Health Insurance Act and the Personal Health Information Protection Act; and
3. consent to the disclosure by GHIP to AZGA Service Canada Inc. of such personal information as may be necessarily required for the processing of my claim for out-of-country health services, including the details of any duplicate payment made directly to me or on my behalf.

Insured's Signature: Date: MM/DD/YYYY GHIP #:
(Government Health Insurance Plan #)

SECTION 8: DIRECTION AND AUTHORIZATION TO PHYSICIANS, HOSPITALS AND OTHER MEDICAL PROVIDERS

By signing this form, I hereby authorize and direct any physician, health care facility, treatment provider, plan administrator, any insurance company, reinsurer, provincial health insurance plan, government department (collectively, "Third Party") having medical or other relevant personal information regarding me, my spouse and/or dependent to disclose, release, share and exchange information with Allianz Global Assistance, its underwriter, plan administrator, agent or representative any and all such information necessary for the purposes of determining my eligibility, assessing my application, investigating and confirming the accuracy and validity of my claim, and administering or processing my claim. I am authorized to act on behalf of my dependants for these purposes. The authorization and direction I provided herein shall be good and sufficient authority, and any copy of this completed form is as valid as the original. My consent and authorization shall remain valid for the duration of my claim unless I revoke these in writing.

Signature of insured / designated legal proxy*: Date: MM/DD/YYYY

* If the patient is a minor, his/her legal guardian must sign on his/her behalf. If a legal representative other than the patient's legal guardian signs this form, (power of attorney, executor/executrix etc.) the provincial health plan requires proof of "Legal Representative" status.

Send your completed forms and original receipts to:

Allianz Global Assistance Claims Department
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Toronto, Ontario M5B 2L7
Canada

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