JF Insurance Agency Group Inc.
www.jfgroup.ca

Ontime Care Worldwide Inc.
15 Wertheim Court, Suite 512
Richmond Hill, Ontario L4B 3H7
Collect worldwide: 905-707-9555
Toll free Canada/U.S.A.: 1-866-209-5804

VISITORS TO CANADA EMERGENCY HOSPITAL & MEDICAL INSURANCE CLAIM FORM

INSTRUCTIONS

IMPORTANT

- In the event of hospitalization, Ontime Care Worldwide Inc. (OTC) 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.

REQUIREMENTS

- Fully completed and signed Claim Form, sections A, B, C & D.
- Emergency room report and/or hospital records if treated at a hospital/outpatient facility.
- 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.

CLINIC SERVICES

- Visitors should go to the nearest clinic, medical centre, or family physician.
- Before leaving the medical service provider, the visitor should obtain a copy of the Physician's medical report. (If any major tests or procedures are to be performed, the visitor must contact Ontime Care Worldwide Inc. for coverage information before proceeding.)
- If the visitor has paid for the services up front, they must obtain a payment receipt for the visit and a pharmacy receipt for any prescription medications (there is no coverage for non-prescription or over-the-counter medications, and we do not reimburse the fees to obtain medical report if one is charged).
- Send in a signed & completed Claim Form, Consent Form, the physician's report(s), original bill(s) and payment receipt(s) to the address on your claim form. If a prescription was filled, be sure to provide the original prescription pharmacy receipt that indicates the medication information and the prescription doctor's information.

TIC claims & travel assistance

SECTION A: CLAIMANT INFORMATION

Insured's First Name: Last Name:

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

Address in Canada

Street Address:

City/Town: Postal Code:

Telephone: ( ) Email:

Country of Origin: Date of Arrival in Canada: MM/DD/YYYY

Name and Address of Family Physician in Country of Origin Name:

Street Address:

City/Town: Postal Code: Telephone: ( )

Name and Address of Family Physician in Canada Name:

Street Address:

City/Town: Postal Code: Telephone: ( )

Do you have other insurance coverage including Canadian government health insurance? Yes No

Do you have insurance coverage through your spouse? ❑ Yes ❑ No

If 'Yes', please provide name and address of other insurance company/coverage:

Name:

Street Address:

City/Town: Postal Code: Telephone: ( )

SECTION B: MEDICAL INFORMATION

Brief description of sickness or injury:

Date symptoms or injury first appeared: MM/DD/YYYY Date you first saw physician for this condition: MM/DD/YYYY

Have you ever been treated for this or a similar condition before? ❑ Yes ❑ No

If 'Yes', give all dates of treatment and list all medication taken **BEFORE** the effective date of the current policy:

Date: MM/DD/YYYY Medication:

Date: MM/DD/YYYY Medication:

SECTION C: EXPENSES CLAIMED

Name of Provider	Diagnosis	Date of Service (MM/DD/YYYY)	Amount Billed	Amount Paid
1.		MM/DD/YYYY		
2.		MM/DD/YYYY		
3.		MM/DD/YYYY		

SECTION D: AUTHORIZATION AND CERTIFICATION

TIC and OTC 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 TIC and OTC's privacy policy, please contact us.

I authorize any doctor, hospital or facility providing medical or health related services, and any other insurer to release and exchange with TIC and OTC or its representatives, any information that is required to process this claim. I assign to TIC and OTC 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 TIC and OTC. 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 TIC and OTC. 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 policy holder of other insurance in Section A (if applicable):