

VISITORS TO CANADA EMERGENCY HOSPITAL & MEDICAL INSURANCE CLAIM FORM

TIC Claims Department
 1200 - 438 University Avenue
 Toronto, ON, Canada M5G 2K8
 Collect worldwide: 416-340-8809
 Toll free Canada/U.S.A.: 1-800-869-6747

INSTRUCTIONS

IMPORTANT

- In the event of hospitalization, TIC Travel Insurance Coordinators Ltd. (TIC) 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.
- Completed Attending Physician/Dentist Statement, Section E.
- 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.

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: _____
 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		
4.		MM/DD/YYYY		

SECTION D: AUTHORIZATION AND CERTIFICATION (CONTINUED ON NEXT PAGE)

TIC 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's privacy policy, please contact us.