## SECTION D: AUTHORIZATION AND CERTIFICATION (CONTINUED FROM PREVIOUS PAGE)

I authorize any doctor, hospital or facility providing medical or health related services, and any other insurer to release and exchange with TIC or its representatives, any information that is required to process this claim. I assign to TIC 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. 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. 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):* ____________

## SECTION E: ATTENDING PHYSICIAN/DENTIST STATEMENT

Name of Patient: ____________ Date of Birth: MM/DD/YYYY

Diagnosis Claimed For: ____________ Date of First Consultation: MM/DD/YYYY

1. When did symptoms for this condition, or injury first occur? MM/DD/YYYY
2. Has the claimant/patient ever had the same or similar condition during the 12 months prior to this visit? ❑ Yes ❑ No
   If 'Yes', please advise: ____________
   Date(s) of all medical visits: MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY
   Diagnosis: ____________
   Treatment Rendered: ____________
3. Was the claimant/patient referred to you? ❑ Yes ❑ No
   If 'Yes', please provide the name/address of referring physician: ____________
4. Are you aware of any other physician in Canada who may have treated this claimant/patient for this or a similar condition? ❑ Yes ❑ No
   If 'Yes', please provide the name/address of this physician: ____________
5. Describe any other diseases or infirmity affecting the condition being claimed for: ____________
6. List all medication(s) claimant/patient was taking at the time of initial consultation: ____________
7. Was the claimant/patient hospitalized? ❑ Yes ❑ No If 'Yes', name of hospital: ____________
   Date of Admission: MM/DD/YYYY Date of Discharge: MM/DD/YYYY
8. Was any surgery performed? ❑ Yes ❑ No
   If 'Yes', please provide name and address of surgeon/hospital: ____________
9. Was this condition due to pregnancy? ❑ Yes ❑ No
   If 'Yes', date of last menstrual period MM/DD/YYYY and expected date of delivery: MM/DD/YYYY
10. Was this condition due to the use of alcohol, misuse of drugs, or self-inflicted injury? ❑ Yes ❑ No
    If 'Yes', please give details: ____________
11. Was this condition due to a motor vehicle accident? ❑ Yes ❑ No If 'Yes', date of accident/injury: MM/DD/YYYY
12. In your opinion, could treatment for the condition have been postponed until the patient's return to country of origin? ❑ Yes ❑ No
    If 'No', please provide details, and date the insured would be medically certified as fit to travel: ____________
    Date fit to Travel: MM/DD/YYYY

### PHYSICIAN'S CERTIFICATION AND SIGNATURE

I certify that the information provided in this section is complete, true and accurate to the best of my knowledge and belief.

Physician's Signature: ____________

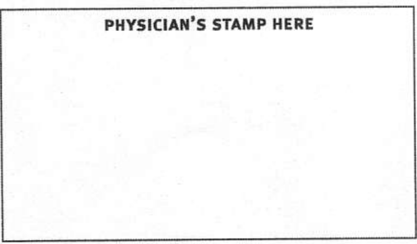
Physician's Name (please print): ____________

Date: MM/DD/YYYY Email: ____________

Street Address: ____________

City/Town: ____________ Postal Code: ____________

Telephone: ( ) ____________ Fax: ( ) ____________




TIC claims & travel assistance