EMERGENCY HOSPITAL & MEDICAL INSURANCE FOR CANADIANS 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 60 days of occurrence.
- You are responsible for any fees charged for completing this form or issuing supporting documentation.
- This form must be completed by the insured, or if a minor, by the legal guardian or parent.

REQUIREMENTS

- Completed and signed claim form and **Emergency Hospital & Medical Insurance for Canadians Medical Certificate.**
- Claim form must be completed by a parent or legal guardian if the insured is a minor.
- 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.
- For Multi-trip Plans, include proof of original departure from and return to your province or territory of residence, such as airline tickets, customs stamp, or other evidence acceptable to TIC.
- Please refer to the claims procedures in the policy booklet or your agent for details on what is required to substantiate your claim.

SECTION A: CLAIMANT INFORMATION

Insured's First Name: ____ Last Name: ____

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

Telephone: (   ) ____ Fax: (   ) ____ Email: ____

Address: ____

City: ____ Province: ____ Postal Code: ____

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

SECTION B: MEDICAL INFORMATION

In the case of an injury, how, when and where did it happen? ____

Please provide the following information if your claim relates to a motor vehicle accident

Name and Address of Auto Insurance Company Name: ____

Street Address: ____

City: ____ Province: ____ Postal Code: ____

Telephone: (   ) ____ Policy number with auto insurance company: ____

If your claim is due to sickness, when did symptoms first appear? MM / DD / YYYY

Date of first treatment: MM / DD / YYYY What is the diagnosis? ____

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

Treating Doctor's Name: ____ Telephone: (   ) ____

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: ____

Name and Address of usual Family Physician Name: ____

Street Address: ____

City: ____ Province: ____ Postal Code: ____

Telephone: (   ) ____ Fax: (   ) ____

Was the condition related to pregnancy? ❑ Yes ❑ No

If 'Yes', date of last menstrual period: MM / DD / YYYY Expected delivery date: MM / DD / YYYY

Was the condition related to the use of alcohol, misuse of drugs, or self-inflicted injury? ❑ Yes ❑ No

If 'Yes', please provide details: ____

SECTION C: EXPENSES CLAIMED

Amounts paid by you will be reimbursed to you if claim is eligible. Otherwise amounts will be paid directly to the provider of service. You are financially responsible for the expenses not covered by your insurance.

Name of Service Provider (for example: doctors, hospital, clinic)	Date of Service	Amount Billed	Amount You Paid
1.	MM/DD/YYYY		
2.	MM/DD/YYYY		

TIC claims & travel assistance