

SECTION D: PROVINCIAL GOVERNMENT HEALTH INSURANCE (GHIP) AUTHORIZATION AND ASSIGNMENT

Residents of Alberta, Saskatchewan, Ontario, Nova Scotia, PEI, and all territories must complete this form in full. Residents of BC, Quebec, and Newfoundland must complete additional forms.

I agree that, according to the terms of this policy and in respect of my applicable provincial government health insurance (GHIP) legislation pertaining to freedom of information and protection of privacy; and in consideration of any monies TIC 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 to my claim for out-of-country health services to TIC directly and I hereby release GHIP, upon payment to TIC, from any further claim or cause of action in connection herewith; and
- 2) Consent and authorize GHIP to directly or indirectly collect information contained in the claim and source document pursuant to Section 39(1) of the Freedom of Information and Protection of Privacy Act, and Section 4(2)(f) of the Health Insurance Act in Ontario only, and
- 3) Consent and authorize GHIP to furnish to any representative of TIC such records and information as may be required for the processing of my claim for out-of-country health services, including the details of any duplicate payment previously made directly to me.

Insured's Signature: _____ Date: MM/DD/YYYY GHIP #: _____

Witness Signature: _____ Date: MM/DD/YYYY Version Code: _____
(Ontario Residents only)

SECTION E: OTHER INSURANCE COVERAGE (if the insured is a minor, this section is applicable to a parent or legal guardian)

Do you have any other travel or out-of-country medical insurance coverage through your employer, your spouse's employer or a retiree plan?
 Yes No If "Yes", provide details below.

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

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

Do you have insurance benefits available through homeowner's insurance, automobile insurance or any other source?

Yes No If "Yes", provide details below.

| Plan | Name of Insurance Company | Policy # | Telephone |
|----------------------|---------------------------|----------|-----------|
| Homeowners Insurance | | | () |
| Automobile Insurance | | | () |
| Other | | | () |

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

Name and address of issuing bank for credit card Name: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

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

Name of Cardholder (please print): _____ Cardholder Signature: _____
(if different from insured)

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

SECTION F: AUTHORIZATION AND CERTIFICATION

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.

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 policyholder of other insurance in Section E (if applicable): _____