INTERNATIONAL STUDENT HOSPITAL & MEDICAL INSURANCE CLAIM FORM

For Provinces Manitoba and West
TIC Claims Department
125 – 4400 Dominion Street
Burnaby, BC, Canada V5G 4G3
Collect worldwide: 604-639-8849
Toll free Canada/U.S.A.: 1-800-882-5246

For Provinces Ontario and East
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.

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- Fully completed and signed Claim Form, sections A, B, C and D.
- Completed Attending Physician/Dentist Statement, Section E.
- Emergency room report and/or hospital records if treated at a hospital or 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 #: 010268

Educational Institution: _____ School Enrollment Date: MM/DD/YYYY

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:

First Name: _____ Last Name: _____

Street Address: _____

City/Town: _____ Postal Code: _____ Telephone: ( )

Name and Address of Family Physician in Canada:

First Name: _____ Last Name: _____

Street Address: _____

City/Town: _____ Postal Code: _____ Telephone: ( )

Do you have any other insurance coverage? ❑ Yes ❑ No

Do you insurance coverage through your spouse's employer? ❑ Yes ❑ No

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

Name: _____

Street Address: _____

City/Town: _____ Postal Code: _____ Telephone: ( )

SECTION B: ME DICAL INFORM ATION

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: EXPENSE S CLAIME D

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

TIC claims & travel assistance

SECTION D: 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 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 this claimed condition: _____
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 and 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 their country of origin? ❑ Yes ❑ No

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: ( )

PHYSICIAN'S STAMP HERE