



TO SUBMIT A CLAIM

HERE ARE THE STEPS TO SUBMIT A CLAIM

Step 1 Gather all your original detailed receipts.

Step 2 Complete and sign the *Claim Form*.

Step 3 Complete and sign your Provincial Health Insurance Plan form.

CHECKLIST

Have you:

- Completed and signed the *Claim Form*?
All incomplete forms will be returned and will delay your claim assessment.
- Attached all original receipts?
Photocopies will not be accepted.
- Completed and signed your Provincial Health Insurance Plan form?
All incomplete forms will be returned and will delay your claim assessment.
- Made photocopies for your records?

IMPORTANT NOTES

- All aforementioned documents must be received within 90 days of your return to your province of residence.
- Cash register coupons (stubs) will not be accepted for reimbursement.
- Any fees for the completion of medical certificates or claim forms are your responsibility.

SEND ALL YOUR DOCUMENTS TO:

LS-Travel
Att: Claims department
247 Thibeau Boulevard
Trois-Rivières (Quebec) G8T 6X9

To verify your claim status:

Toll free: 1-877-344-8398
Email: claimsfollowup@tourmed.ca

Group Out-of-Province Travel Medical Emergency Insurance

This claim form is mandatory whether you have incurred out of pocket expenses or not.

This claim form must be completed, signed and returned to the Insurer as soon as possible but no later than 90 days after your return in your province of residence. If you need assistance in completing this claim form, our Claims team will answer your questions from Monday to Friday, 8:30AM to 5:00PM EST. Call toll free 1-877-344-8398 or collect 1-819-377-1777.

PLEASE SUBMIT THE APPLICABLE SUBSTANTIATING DOCUMENTATION

- Original detailed invoices or receipts. Please note that photocopies or cash/cashier receipts are not accepted.
- **A proof*** of your **Departure date** from your province of residence is mandatory.
 (* boarding pass, plane ticket, credit card receipt, confirmation obtained at the border/immigration).

PARTICIPANT'S STATEMENT

Name of the Insured and address where to send the refund. Desired currency: CAD USD

First name _____ Last name _____ Contract Number _____

No. _____ Street _____ apt. # _____ City _____ Province _____ Postal Code _____

Government Health Insurance Number _____ Telephone: (_____) _____ Date of birth: ____ / ____ / ____
dd mm yy

Email Address: _____

Name of the employer: _____

Are you covered by any other travel insurance (private, group, Medicare, credit card)? YES NO

Company : _____ Policy Number : _____ Telephone : (_____) _____

DEPENDANTS - to be completed if the claim is for a Dependant

First Name _____ Last Name _____

Date of Birth: ____ / ____ / ____ Relationship with Participant: _____
dd mm yy

Signature of the Dependant (if has reached age of majority) _____

If the claim is for a Dependant child:

Is he/she married? YES NO Does he/she usually live with the Participant? YES NO

Is he/she a student in a Cegep (college) or university? YES NO

If yes, name and address of the educational institution: _____

CLAIM EXPENSES

Provide brief description of the expenses and indicate amounts incurred. (If you need more space, please attach a separate sheet).

Name of medical services provider (or any type of services incurred)	Date of service received (dd/mm/yy)	Amount billed	Amount paid by you	Currency
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	

CLAIM FOR MEDICAL EXPENSES (PLEASE ANSWER ALL QUESTIONS)

a) Please check the appropriate box: Sickness Accident Other Please specify: _____

b) Treatment received in: Office/clinic Emergency Room of a hospital Hospital

c) Have the expenses been incurred during a business trip? YES NO

d) Please provide dates and brief details about this claim.

e) In the past, have you ever been treated for those symptoms or illnesses? YES NO

If YES, please provide the dates and places of consultation.

f) Please provide name and contact information of your family doctor in Canada.

I don't have a family doctor

Name: _____ Telephone: _____

Address: _____

CERTIFICATION AND AUTHORIZATION

I hereby assign to LS-Travel Insurance Company (the Insurer) any benefits obtained from other sources for losses covered under this policy. I also direct these sources to forward payment to the Insurer for my claims submitted by the Insurer with regard to these losses and authorize all parties above to exchange and share information to facilitate the claims process.

I hereby authorize any physician, hospital, other health care practitioners, medical care facilities, insurance carriers, any other person who has attended or examined me and any other source involved in this claim to provide the Insurer any medical and other information needed to process the claim. I also consent that such information be shared with other sources for the Insurer to be able to coordinate the payment of benefits when applicable.

I certify that I have no other insurance coverage than the ones mentioned in this claim form.

I understand that the making of false or fraudulent statement in connection with a claim for benefits will render the insurance policy null and void.

I certify that the statements given in the making of this claim are complete, true and correct to the best of my knowledge.

A photocopy, facsimile or electronic copy of this authorization shall be considered as effective and valid as the original.

Signature of the claimant spouse (if applicable): _____ **Date:** _____

Signature of the Participant: _____ **Date:** _____

The information on this form is being collected and used by Alberta Health pursuant to sections 20(a) and (b) of the Health Information Act and section 33(c) of the Freedom of Information and Protection of Privacy Act for the purpose of assigning the payment of insured medical under the Alberta Health Care Insurance Plan and insured hospital services under the Hospitalization Benefits Plan to the insurer of third party named in this form. If you have questions about the collection and use of this information, please contact an Alberta Health representative toll free within Alberta at 310-000 then 780-427-1432.

Note: Failure to complete all sections of this form will result in Alberta Health not releasing health information or reimbursing an insurance claim. Proof of payment must be submitted with the insurance claim.

Patient Information

Name of Patient - please print Alberta Personal Health Number (PHN) PHN of Patient

Authorization for Release of Health Information

My health information can be released to: LS TRAVEL INSURANCE COMPANY

Name of insurance company, and where applicable, the name of a broker submitting on behalf of the insurance company, or third party who is not an insurer (e.g. junior hockey clubs, churches).

to permit Alberta Health for reimbursement of health benefits paid on my behalf for the cost of insured health services by the insurer or third party which I received outside of Alberta.

Authorization of Payment

I, Name of Patient hereby assign to Name of Payee

any amounts payable to me by Alberta Health for out of country health benefits.

Effective Date

This consent is effective From Date (yyyy-mm-dd) (Departure date) To Date (yyyy-mm-dd) (at least 18 months from the earliest date of service to ensure sufficient time for processing). Please note: the submitter has up to 365 days from the date of medical service to submit a claim to Alberta Health.

Declaration

I, the patient, authorize disclosure of the following information for the purposes of Alberta Health to reimbursing health benefits paid on my behalf for the cost of insured health services received outside of Alberta, which may include the following: date(s) of service(s), type(s) of service(s) and reason(s) for service(s), amount(s) paid, name(s) of service provider(s), and where applicable, the facility name, and personal health number.

I also understand I have been asked to authorize disclosure of this information so as to permit Alberta Health to reimburse the identified insurance company, or third party who is not an insurer that has paid a medical service claim on my behalf, and I am aware of the risks and benefits of consenting, or refusing to consent to the disclosure. I further understand that this consent may be revoked by submitting such revocation to the Out-of-Country Claims Unit of Alberta Health.

I, certify that the information provided above on this form is true and correct.

Please print name of person signing Signature of person completing request (if 18 years of age and over) - or - Signature of authorized representative (if person completing request is under 18 years of age or wholly dependent on the authorized representative by reason of mental or physical infirmity).

Please return this completed form to secondary insurance company.

If this document is being signed by someone other than the resident or the resident's parent, the individual signing must be a legal representative of the resident and must be accompanied by notarized copies of any legal documents that establish to the satisfaction of Alberta Health the individual's legal authorization to sign on behalf of the resident.