Medical Claim Form

FOR CLAIMS INQUIRIES PLEASE CONTACT:
AIR MILES® TRAVEL INSURANCE
at 1 866-298-6581.

SUBMIT CLAIM TO:
AIR MILES TRAVEL INSURANCE
c/o Manulife Financial
PO BOX 4902, Station A
Toronto ON M5W 0A9

IN QUÉBEC:
AIR MILES TRAVEL INSURANCE
c/o Manulife Financial
CP 99, Stn St-Martin
Laval, Québec H7V 3P4

UNDERWRITTEN BY THE MANUFACTURERS LIFE INSURANCE COMPANY AND FIRST NORTH AMERICAN INSURANCE COMPANY, A WHOLLY OWNED SUBSIDIARY OF MANULIFE FINANCIAL.

CLAIMS WILL NOT BE PROCESSED UNTIL THE REQUIRED SECTIONS HAVE BEEN FULLY COMPLETED AND SUBMITTED WITH ALL OF THE REQUIRED DOCUMENTATION

Please remember to complete both sides and all applicable sections of this form and submit with the original receipts for any out-of-pocket expenses incurred as well as documentation to support the diagnosis and treatment of the sickness or injury. **Incorrect or incomplete claim forms will delay settlement of the claim.**

For claims related to Travel Accident, Baggage, Personal Money and Rental Vehicle Damage, please contact AIR MILES TRAVEL INSURANCE at 1 866-298-6581.

Claimant Information and Explanation of Loss THIS SECTION TO BE COMPLETED IN FULL BY ALL CLAIMANTS

CLAIMANT 1 Mr/Mrs/ Miss/Ms	Insured Last Name	First Name	Birth Date D M Y	Amount Claimed/Currency
Policy/Confirmation Number	Government Health Insurance Plan Number			Version Code (Ontario residents)
CLAIMANT 2 Mr/Mrs/ Miss/Ms	Insured Last Name	First Name	Birth Date D M Y	Amount Claimed/Currency
Policy/Confirmation Number	Government Health Insurance Plan Number			Version Code (Ontario residents)

Address for Correspondence or Claim Payments No./Street/Apt. | City

Province | Postal Code | Home Telephone No. | Business Telephone No. | E-mail

Date of Departure D M Y | Departure Point | Destination | Date of Return D M Y | Date of Sickness/Injury D M Y

Name of person who completed this form | Relationship to claimant | Date Claim Submitted D M Y

Describe in detail the cause and circumstances of the sickness or injury

Location of sickness or injury: City | State/Province | Country | Were you hospitalized? Yes ◯ No ◯ | Admission Date D M Y | Discharge Date D M Y | Date you returned to Canada D M Y

Did you contact the assistance provider (24 hour service) at the time of the sickness or injury? Yes ◯ No ◯ | Assistance File No. | Has the bill been paid? No ◯ Yes ◯ ▶ In Full ◯ In Part ◯ ▶ | Amount Paid

Have you submitted this claim to your government health insurance provider? Yes ◯ No ◯ | Amount Claimed/Refunded | Have you submitted this claim to any other plan? Yes ◯ No ◯ | Amount Claimed/Refunded

Name of Parent or Guardian if Claimant under age 16

Name of your spouse (if applicable) | Full name of your usual physician in your province of residence

No./Street/Suite No. of your usual physician

City | Province | Postal Code | Telephone No.

Were you hospitalized for this sickness/injury (or related condition(s)) in the last 12 months prior to the departure date shown in the policy application? No ◯ Yes ◯ ▶ If Yes, please provide name and address of hospital ▶

Authorization and Release THIS SECTION MUST BE COMPLETED IN FULL BY ALL CLAIMANTS

By signing below, I hereby consent to, authorize and direct that Manulife Financial may recover from my Government Health Insurance Plan (GHIP) and/or any other Health Insurance carriers or entities, payments which were made to others on my behalf for out-of-province health services.

Furthermore, I agree that, pursuant to any applicable federal, provincial or territorial health insurance legislation or, in Ontario, the Personal Health Information Protection Act, 2004, as it pertains to freedom of information and protection of privacy, I hereby:

1. Direct and authorize the Government Health Insurance Plan (GHIP) to make payment in respect of my claim for out-of-province health services to Manulife Financial or its representative, and upon such payment, I hereby release GHIP from any further claim or cause of action in connection with such claim; and
2. Consent to and authorize GHIP to directly or indirectly collect information contained in the claim and source documents pursuant to applicable provincial legislation; and
3. Consent to the disclosure by GHIP to Manulife Financial or its representative of such personal health information as may be necessarily required to process my claim for out-of-province health services, including the details of any payment previously made directly to me or on my behalf.

Authorization to Physicians, Hospitals, other Health Care Practitioners, Medical Care Facilities, Insurance Carriers, any other Person who has attended or examined me and Other Sources:

I hereby authorize and direct that you release to Manulife Financial any and all of my personal health information (and any other personal information as may be required to adjudicate my claim under this policy) you have regarding me, while under your professional care, including my medical history, any illness, injury, consultation, medicines or treatment and copies of all hospital and medical records. This authorization will permit Manulife Financial to use the disclosed information for the purpose of determining my eligibility for coverage under my travel insurance policy, assessing insurance risks, managing my claim and negotiating or settling payments to third parties. This authorization will permit Manulife Financial's representative to use the disclosed information for the purpose of determining my eligibility for coverage under my travel insurance policy and processing my claim.

I hereby assign to Manulife Financial any benefits obtained from other sources for losses covered under this policy. I also direct these sources to forward payment to Manulife Financial for my claims submitted by Manulife Financial with regard to these losses. A photocopy, facsimile or electronic copy of this authorization is acceptable.

Attention travel services providers:

I hereby authorize and direct that you release to Manulife Financial or its representative any and all information you have regarding my travels or use of your travel services for the purpose of determining my eligibility for coverage and or for benefits under my travel insurance policy.

This authorization will also permit Manulife Financial to release and share information with any or all parties noted above.

I certify that the statements and particulars given herein together with those on any accompanying documents are complete, true and correct to the best of my knowledge.

I understand that I can refuse to sign this consent form. I am aware that if my personal information is necessarily required for processing and adjudication of my claim, my refusal to sign this consent form may jeopardize my entitlement to benefits under this insurance policy. I understand that I may revoke this consent at any time by written notification to Manulife Financial and/or its representative. I also understand that the making of false or fraudulent statements in connection with a claim for benefits may render the certificate of insurance or the policy void.

Date of Consent D M Y | End Date of Consent: 12 Months from Date of Signature

CLAIMANT 1 Signature of Insured / Insured's Guardian | Date of Signature D M Y

CLAIMANT 2 Signature of Insured / Insured's Guardian | Date of Signature D M Y

Government Health Insurance Plan Section (GHIP) AUTHORIZATION & RELEASE

IMPORTANT: ENSURE THAT ALL SECTIONS ARE FULLY COMPLETED EVEN IF THE ANSWER IS N/A (Non Applicable)

RESIDENTS OF B.C. AND ONTARIO:

You must complete and sign the Government Health Insurance Plan (GHIP) Authorization and Release section provided ON THE OPPOSITE SIDE OF THIS FORM.

QUÉBEC RESIDENTS:

You must complete the Québec GHIP form and include this with your claim. You can contact the AIR MILES TRAVEL INSURANCE Customer Service Centre at 1 866-298-6581 or send a request by email (airmilestravelinsurance@manulife.com) to obtain the required GHIP Authorization and Release form.

ALL CLAIMANTS:

Must complete and sign the Authorization and Release section IMMEDIATELY ABOVE.

GHIP SECTION CONTINUES ON BACK

FOR OFFICE USE ONLY

Coverage With Other Insurers and Other Sources THIS SECTION TO BE COMPLETED IN FULL BY ALL CLAIMANTS

You may have travel protection through other sources such as a credit card or your employer. We require the following information in order to coordinate benefits with these sources.

Do you have any travel protection with any of your credit cards? Yes ◯ No ◯	Credit Card No. (First 6 Digits)	Specific Card Type (i.e., CIBC Platinum, VISA)	Name of Cardholder

Employee Group Benefits Plan Or Retired Employee Group Benefits Plan Yes ◯ No ◯	Group Policy No.	Name of Covered Person	Identification No.	Name of Insurance Company

Any other coverage (i.e., Union, Pensioner, Private Or Other Policy Or Other Sources Of Recovery) under which you are entitled to benefits? Yes ◯ No ◯	Policy No.

Name and Address of Insurance Company/Broker

Other Sources Name and Address of Company

Claimant's (or Parent's) Occupation Full Time Employment ◯ Self Employed ◯ Part Time Employment ◯ Student ◯ Retired ◯ Unemployed ◯ Other

Name of your Employer	Address: No./Street/Suite No.		
City	Province	Postal Code	Telephone No.
Name of Spouse's Employer	Address: No./Street/Suite No.		
City	Province	Postal Code	Telephone No.

Was the medical emergency caused by an accident? No ◯ Yes ◯	Please provide the contact information for the responsible third party Name	Address	Telephone No.

RESIDENTS OF BRITISH COLUMBIA: THIS SECTION MUST BE COMPLETED PRIOR TO ANY MEDICAL CLAIM PAYMENTS
Government Health Insurance Plan (GHIP) Authorization and Release section

AUTHORIZATION TO PROVIDE MEDICAL INFORMATION AND ASSIGNMENT OF PAYMENT TO INSURED PERSON OR BENEFICIARY UNDER THE MEDICARE PROTECTION ACT OR HOSPITAL INSURANCE

BETWEEN _____ of the first part hereinafter referred to as the Assignor

AND THE MANUFACTURERS LIFE INSURANCE COMPANY (MANULIFE FINANCIAL) C/O PO BOX 4902, Station A, Toronto ON M5W 0A9 of the second part, hereinafter referred to as the Assignee

AND HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF BRITISH COLUMBIA AS REPRESENTED BY THE MINISTER OF HEALTH hereinafter referred to as the Minister

WHEREAS the Assignor is a person eligible for insured services or benefits or both under the Province of British Columbia's Medicare Protection Act or Hospital Insurance Act or both, and as such may receive payment for the above services from the Minister.

And WHEREAS the Assignor is under a covenant or obligation under a contract with the Assignee to remit to the Assignee all such payments received for medical services from the Minister.

NOW WITNESSETH THAT in consideration of the said obligation to the Assignee the Assignor hereby assigns unto the Assignee all sums of money that shall be owing to the Assignor by the Minister for the above noted contract. The Minister is hereby authorized to pay all such sums directly to the Assignee at the address aforesaid, or at any address the Assignee may from time to time designate, with payment of any such sum to be sufficient discharge to the Minister of and from any indebtedness in that amount to the Assignor, his heirs, executors, or administrators.

I HEREBY CONSENT TO AND AUTHORIZE THE MINISTRY OF HEALTH TO FURNISH ANY REPRESENTATIVE OF THE MANUFACTURERS LIFE INSURANCE COMPANY (MANULIFE FINANCIAL) ANY AND ALL RECORDS AND INFORMATION IN THE MINISTRY OF HEALTH'S POSSESSION REGARDING CLAIMS FOR MEDICAL SERVICES INCURRED WHILE I HAD INSURANCE COVERAGE FOR THE ASSIGNMENT PERIOD INCLUDING MEDICAL HISTORY AND PHYSICAL CONDITION BOTH PRIOR AND SUBSEQUENT TO RECEIPT OF MEDICAL SERVICES, REGARDLESS OF LAPSED TIME AND BEARING IN ANY WAY ON THE SERVICES RECEIVED DURING THE ABOVE TIME PERIOD.

DATED this day of , 20 _____	Signature of Assignor

Assignment	Effective From: D M Y	To: D M Y	Personal Healthcard No.

Witness Signature	Occupation

No./Street/Suite No.

City	Province	Postal Code	Telephone No.

RESIDENTS OF ONTARIO: THIS SECTION MUST BE COMPLETED PRIOR TO ANY MEDICAL CLAIM PAYMENTS
Government Health Insurance Plan (GHIP) Authorization and Release section

AUTHORIZATION TO PROVIDE MEDICAL INFORMATION AND ASSIGNMENT OF PAYMENT TO INSURED PERSON OR BENEFICIARY UNDER THE MEDICARE PROTECTION ACT OR HOSPITAL INSURANCE

1. **DIRECTION AND RELEASE**

I, _____ irrevocably direct and authorize the Ontario Ministry of Health and Long-Term Care ("the Ministry") to make payment in respect of my claim for out-of-country health services to The Manufacturers Life Insurance Company (Manulife Financial) directly and I hereby release OHIP, upon payment to Manulife Financial from any further claim or cause of action in connection therewith.

2. **CONSENT**

◯ **If providing consent for self:**

I authorize the Ministry to collect my personal health information, consisting of:
- information relating to my receipt of health care services outside of Canada, and
- information relevant to the reimbursement of those services under the Health Insurance Act, R.S.O. 1990, c. H.6

from Manulife Financial, and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying my request for payment under the Health Insurance Act, including the details of any duplicate payment previously made to me, to Manulife Financial.

I understand the purpose for the Ministry's collection and disclosure of this personal health information.

I understand that I can refuse to sign this consent form.

◯ **If providing consent on behalf of a person who is not capable of consenting to the collection, use and disclosure of personal health information:**

I, _____ am the substitute decision-maker for _____ . I authorize the Ministry to collect personal health information about the Insured Person, consisting of:

- information relating to the Insured Person's receipt of health care services outside of Canada, and
- the reimbursement of those services under the Health Insurance Act, R.S.O. 1990, c. H.6.

from Manulife Financial, and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying my request for payment under the Health Insurance Act, including the details of any duplicate payment previously made to me, to Manulife Financial.

I understand the purpose for the Ministry's collection and disclosure of this personal health information.

I understand that I can refuse to sign this consent form.

Note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.

3. **AUTHORIZATION**

My Name		Witness Name	
Address		Address	
Home Telephone No.:	Work Telephone No.:	Home Telephone No.:	Work Telephone No.:
Signature	Date D M Y	Signature	Date D M Y