CLAIM FORM



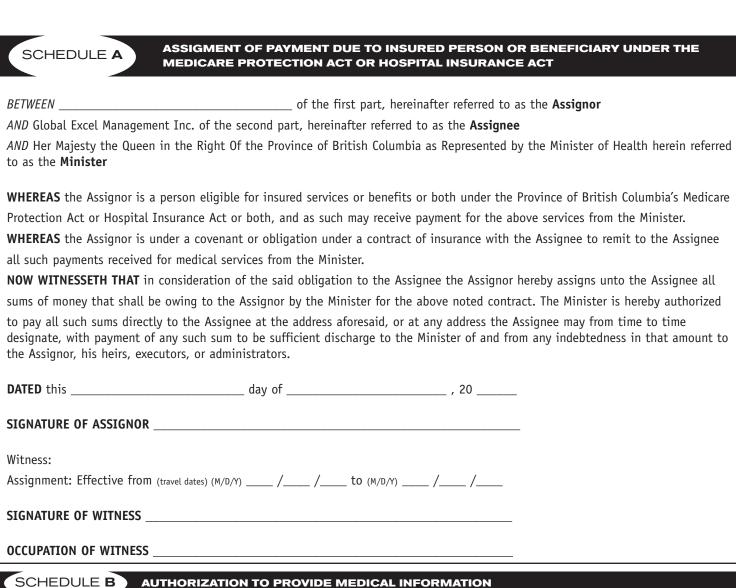
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laim no.		

Send your completed form to:

In CANADA: Global Excel Management Inc., 73 Queen Street, Sherbrooke, QC J1M OC9 / In U.S.A.: Global Excel Management Inc., P.O. Box 10, Beebe Plain, VT 05823

IMPORTANT: Failure to sign both sides of this form will result in a delay of the processing of your claim.

SECTION A CLAIMANT INFORMATION (Please print)							
PATIENT'S INFORMATION		POLICYHOLDER'S INFORMATION					
Last name Fin	rst name	Initial	Last name	First name		Initial	
☐ Male ☐ Female	Date of birth (M/I		Address (number & street)		Date o	f birth (M/D/Y)	
Relationship: Self Spou			City		Province	Postal code	
Provincial health number:			Home () Work ()				
Family physician & all other physicians consulted within the ninety days prior to the date of departure		Diagnosis of illness or injury (while travelling)					
Country where claim occured			Date of incident (M/	, ,			
Trip dates (M/D/Y) From:/ To: _			182 days, please provide pro surance extension.	of of Please i	ndicate on e paid it or	each bill whether not.	
SECTION B OTHE	ER INSURANCE INFORI	MATION					
Patient's (or parent's) occupation: Full-time employment Self-employed Student Retired Other:							
Name of your employer:							
Address: No Street				<i>!</i>			
Province	Postal	code	Telephone ()			
Name of spouse's employer:							
Address: No Street				<i>I</i>			
Province	Postal	code	Telephone ()			
Employee group benefits plan: Yes No Group policy no Name of covered person							
		Date of birth of insured (M/D/Y)//					
Credit card coverage: Yes No Credit card no.							
Any other coverage (e.g., union, pe	nsioner, private or other policy	purchased pr	ior to your departure): 🔲	Yes 🔲 No			
Policy no Name and address of insurance company/broker:							
Are you covered by US Medicare: Yes No Plan no Type: A B Both							
AS INDICATED IN YOUR POLICY, YOUR TRAVEL INSURANCE PLAN PROVIDES COVERAGE IN EXCESS OF YOUR PROVINCIAL HEALTH INSURANCE PLAN AND ANY OTHER APPLICABLE INSURANCE. FOR GLOBAL EXCEL MANAGEMENT INC. TO SEEK REIMBURSEMENT FROM THESE SOURCES, YOU MUST COMPLETE THE FOLLOWING SECTIONS.							
SECTION C AUTHORIZATION TO PHYSICIANS, HOSPITALS, AND OTHER MEDICAL PROVIDERS							
 I, the undersigned, hereby authorize any hospital, physician, or medical facility to send my medical information to Global Excel Management Inc., authorized representatives of the insurer. I further consent to the disclosure of this information by Global Excel Management Inc. to other sources as may be required to obtain benefits from other sources. I warrant that neither I nor any Insured Person have any additional coverage throat any other insurer (other than that listed above). I understand that my insurance shall be void if, whether before or after the loss, person has concealed or misrepresented any fact or circumstance concerning claim. 				or after the loss, any			
Canada and Global Excel Management Inc. any benefits obtainable from other sources for covered losses under this policy. I also direct these sources to forward payment to Global Excel Management Inc. with regard to these losses.							
Patient's or authorized person's signature Date							
FOR COMPANY Fraud Verification	A:		Fraud Verification	n B:			



OCCUPATION OF WITNESS						
SCHEDULE B AUTHORIZATION TO PROVIDE MEDICAL INFORMATION						
consent to and authorize the and information in the Minist from (M/D/Y) / /	(or I, (or I,	oresentative of Global Excel Man ims for Medical Services incurred medical history and physical cor	nagement Inc. any and all records d while I had insurance coverage ndition both prior and subsequent			
DATED this	day of	, 20				
Personal Health Number						
SIGNATURE						
Address						

For Claim inquiries, call 1-800-336-9224 or 819-566-8698.

Telephone