CLAIM FORM

GlobalExcel®

Policy no. _____

Claim no. _____

Send your completed form to:

In CANADA: Global Excel Management Inc., 73 Queen Street, Sherbrooke, QC J1M 0C9 / 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	First name	Initial	Last name	First name	Initial
❑ Male ❑ Female	Date of birth (M/D/Y) _____/_____/_____		Address (number & street)		Date of birth (M/D/Y) _____/_____/_____
Relationship: ❑ Self ❑ Spouse ❑ Dependent ❑ Check if child is full-time student			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/D/Y) _____/_____/_____		Currency
Trip dates (M/D/Y) From: _____/_____/_____ To: _____/_____/_____		For trips exceeding 182 days, please provide proof of provincial health insurance extension.			**Please indicate on each bill whether you have paid it or not.**

SECTION B OTHER INSURANCE INFORMATION

Patient's (or parent's) occupation: ❑ Full-time employment ❑ Self-employed ❑ Student ❑ Retired ❑ Other: _____

Name of your employer: _____

Address: No. _____ Street _____ Suite no. _____ City _____

Province _____ Postal code _____ Telephone ( ) _____

Name of spouse's employer: _____

Address: No. _____ Street _____ Suite no. _____ City _____

Province _____ Postal code _____ Telephone ( ) _____

Employee group benefits plan: ❑ Yes ❑ No Group policy no. _____ Name of covered person _____

Identification no. _____ Name of insurance company _____ Date of birth of insured (M/D/Y) _____/_____/_____

Credit card coverage: ❑ Yes ❑ No Credit card no. |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Card type/bank: _____ Name of the cardholder: _____

Any other coverage (e.g., union, pensioner, private or other policy purchased prior 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

1. 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.
2. I, the undersigned, hereby assign to Royal & Sun Alliance Insurance Company of 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.
3. I warrant that neither I nor any Insured Person have any additional coverage through any other insurer (other than that listed above).
4. I understand that my insurance shall be void if, whether before or after the loss, any person has concealed or misrepresented any fact or circumstance concerning this claim.

Patient's or authorized person's signature _____ **Date** _____

FOR COMPANY USE ONLY

Fraud Verification A: **Fraud Verification B:**

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

SCHEDULE "A"
AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

I, _____ (or, I _____ parent/guardian of _____, a minor) hereby consent to and authorize Manitoba Health to furnish to any representative of _____, claim and payment information in Manitoba Health's possession in respect of claims for Medical Services incurred for which I had insurance coverage from _____ including physician/hospital name, date of service, and services provided (in-patient, out-patient, physiotherapy, visit, procedure, x-ray or laboratory services).

ASSIGNMENT OF PAYMENT DUE TO REGISTRANT UNDER THE HEALTH SERVICES INSURANCE ACT

I, _____ (or, I _____ parent/guardian of _____, a minor) hereby direct Manitoba Health to forward payment to _____, for any claims for benefits under the Health Services Insurance Act submitted by _____ in respect for medical and hospital services provided outside Canada.

DATED this _____ day of _____ , 20____

_____ _____
Manitoba Health Registration Number SIGNATURE

_____
Address

_____

_____ _____
Personal Health Identification Number Telephone

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