HOW TO SUBMIT A CLAIM – INPATRIATES TO CANADA

Complete Claims Management Professionals (CCMP)

IMPORTANT

- 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.

TO SUBMIT YOUR CLAIM :

STEP 1 Gather all your claim documentation
STEP 2 Complete and sign the claim form
STEP 3 Complete the checklist below
STEP 4 Mail all documentation to CCMP

CHECKLIST

Do you have:

- ❑ The fully completed claim form, signed and dated?
  - ❑ Sections 1, 2, 3, 4 & 6 (completed by you)
  - ❑ Section 5 (completed by your attending physician/dentist)

  Incomplete claim forms will be returned to you and this will delay the processing of your claim submission.
- ❑ Emergency room report and/or hospital records (if treated at a hospital/outpatient facility)?
- ❑ All original receipts?

  Photocopies will not be accepted.
- ❑ A copy of all documents for your records?

Send your completed forms and original receipts to:

CCMP Claims Department
4 – 160 Pony Dr., 2nd Floor
Newmarket, Ontario, Canada L3Y 7B6

To check your claim status, please call:

Toll-free Canada/USA: 1-866-209-0112
Collect worldwide: 905-830-9629
E-mail: claims@ccmp.ca

CLAIM FORM – VISITORS TO CANADA

Complete Claims Management Professionals
CCMP

SECTION 1: PRIVACY AND DECLARATION

CCMP Privacy Statement

CCMP is committed to protecting the privacy, confidentiality, accuracy, and security of the personal information that it collects, uses, retains, and discloses while conducting business.

At CCMP, we recognize and respect the importance of privacy. When you enroll for insurance coverage or submit a claim, we establish a confidential file and collect, use, and disclose your personal information for the purposes of issuing, administering, adjudicating and/or servicing your insurance. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other persons we have authorized who have a need to know it to perform their duties. Our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security extends to the contracts and agreements we sign with external suppliers and service providers. We may store or process your personal information in Canada, the United States or other countries for processing, storage, analysis, or disaster recovery and, under applicable law, governments, courts, law enforcement or regulatory agencies, may, by lawful order, obtain disclosure of your personal information. If you have any questions regarding our privacy practices, please contact the Privacy Officer at:

CCMP Claims Department
4 – 160 Pony Dr., 2nd Floor
Newmarket, Ontario, Canada L3Y 7B6

Telephone: 1-866-209-0112
E-Mail: claims@claims.ca

If you do not agree with our use and disclosure of your information in connection with your application and servicing any policy that we issue, we will not be able to offer you the insurance product you are interested in, service your insurance or adjudicate your claim.

I have read and understood the privacy statement and I consent to the collection, use, retention, and disclosure of my personal information or those of my dependents for the purposes stated above. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated.

I hereby assign to CCMP any benefits obtainable from other sources for losses covered under this policy. I authorize and direct these sources to release payments to CCMP and for CCMP to release pertinent payments to other parties for the purposes of processing my claim.

I certify that the information contained herein is true, complete, and accurate and that each of the listed expenses was purchased and/or incurred in connection with the medical treatment of the individual(s) named below. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning this claim, I acknowledge and agree that CCMP may investigate any information about me, my spouse and/or dependents pertaining to this claim, which may be used and disclosed to any relevant Third Party, and where applicable my plan sponsor, for the purpose of investigating and preventing fraud and/or plan abuse.

If I receive payment from CCMP in an amount that exceeds the benefit(s) to which I am entitled under the policy (the "overpayment amount"), then I acknowledge and agree that: (a) I am indebted to CCMP for such overpayment; (b) CCMP has the right to recover the overpayment amount through any means available by law; and (c) CCMP will offset any benefits payable to me by the overpayment amount until CCMP has recovered the overpayment amount in full.

I declare my statements above, including all other past and future statements made through personal or telephone interviews relating to my claim, to be true, complete, current, and accurate.

Insured's Signature: _____ Date : _____

Insured's Name (please print): _____ Policy #: _____

CLAIM FORM – VISITORS TO CANADA

Complete Claims Management Professionals (CCMP)

SECTION 2: INSURED'S INFORMATION

Insured's First Name: Last Name:

❑ Male ❑ Female Date of Birth: Policy #:

Address in Canada

Street Address:

City: Province: Postal Code:

Telephone: ( ) Email:

Country of former Origin : Date of Arrival in Canada:

Name and Address of Physician in Country of Origin:

First Name: Last Name:

Street Address:

City/Town: Postal Code: Telephone: ( )

Name and Address of Physician in Canada:

First Name: Last Name:

Street Address:

City/Town: Postal Code: Telephone : ( )

Do you have other insurance coverage including Canadian government health insurance? ❑ Yes ❑ No

Do you have insurance coverage through your spouse? ❑ Yes ❑ No

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

Name:

Street Address:

City/Town: Postal Code: Telephone : ( )

SECTION 3: MEDICAL INFORMATION

Brief description of sickness or injury:

Date symptoms or injury first appeared :

Date you first saw physician for this condition:

In the case of an injury, how, when and where did it happen?

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: Medication:

Date: Medication:

Date: Medication:

SECTION 4: EXPENSES CLAIMED

Name of Provider	Diagnosis	Date of Service	Amount Billed	Amount Paid
1.				
2.				
3.				
4.				
5.				

CLAIM FORM – VISITORS TO CANADA

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SECTION 5: ATTENDING PHYSICIAN/DENTIST STATEMENT

Name of Patient: _____ Date of Birth: _____

Diagnosis Claimed For: _____ Date of First Consultation: _____

1. When did symptoms for this condition, or injury first occur? _____
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: _____
   Diagnosis: _____ Treatment Rendered: _____
3. Was the claimant/patient referred to you? ❑ Yes ❑ No
   If "Yes", please provide the name/address of the 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 the condition being claimed: _____
6. List all medication(s) claimant/patient was taking at the time of initial consultation: _____
7. Was the patient hospitalized? ❑ Yes ❑ No If "Yes", name of hospital:
   Date of Admission: _____ Date of Discharge: _____
8. Was any surgery performed? ❑ Yes ❑ No
   If "Yes", please provide name and address of surgeon and hospital: _____
9. Was the condition due to pregnancy? ❑ Yes ❑ No
   If "Yes", date of last menstrual period: _____ Expected date of delivery: _____
10. Was the condition due to the use of alcohol, misuse of drugs, or self-inflicted injury? ❑ Yes ❑ No
    If "Yes", please give details: _____
11. Was the condition due to a motor vehicle accident ? ❑ Yes ❑ No If "Yes", date of accident/injury: _____
12. In your opinion, could treatment for the condition have been postponed until the patient's return to their country of origin? ❑ Yes ❑ No
    If "No", please provide details, and date the insured would be medically certified as fit to travel: _____
    Date fit to travel: _____

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 STAMP HERE

Physician's Signature: _____

Physician's Name (please print): _____

Date : _____ Email: _____

Street Address: _____

City/Town: _____ Postal Code: _____

Telephone: ( ) _____ Fax: ( ) _____

CLAIM FORM – VISITORS TO CANADA

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SECTION 6: DIRECTION AND AUTHORIZATION TO PHYSICIANS, HOSPITALS AND OTHER MEDICAL PROVIDERS

By signing this form, I hereby authorize and direct any physician, health care facility, treatment provider, plan administrator, any insurance company, reinsurer, provincial health insurance plan, government department (collectively, "Third Party") having medical or other relevant personal information regarding me, my spouse and/or dependent to disclose, release, share and exchange information with CCMP, its underwriter, plan administrator, agent or representative any and all such information necessary for the purposes of determining my eligibility, assessing my application, investigating and confirming the accuracy and validity of my claim, and administering or processing my claim. I am authorized to act on behalf of my dependents for these purposes. The authorization and direction I provided herein shall be good and sufficient authority, and any copy of this completed form is as valid as the original. My consent and authorization shall remain valid for the duration of my claim unless I revoke these in writing.

Full Name of Patient/Insured (please print): Date :

I authorize payment of this claim to (print name):

Insured's signature (if minor, signature of parent or legal guardian):

Signature of policyholder of other insurance in Section 2 (if applicable):