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

WWW.TOURMED.CA
Telephone : 1 877 344-8398
Fax : 1 819 377-6069

247 Thibeau Blvd.
Trois-Rivières (Québec) G8T 6X9

CLAIM FORM

Insured by

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 no later than 90 days after you return to 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
  - ✓ **The US $5 co-pay for each prescription is NOT REFUNDABLE**
- **A proof*** of your **Departure date** from your province of residence is mandatory for claims submitted under the **ANNUAL PLAN**
  (* boarding pass, plane ticket, credit card receipt, confirmation obtained at the border/immigration).

CLAIMANT'S STATEMENT

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

First name _____ Last name _____ Policy Number _____

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

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

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

Company:_____ PolicyNumber:_____ Telephone:(_____)_____

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 (mm/dd/yyyy)	Amount billed	Amount paid by you	Currency
		$	$	
		$	$	
		$	$	
		$	$	
		$	$	
		$	$	

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

_____

_____

_____

_____

d) 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.

_____

_____

2. CLAIM FOR EMERGENCY ROUND TRIP EXPENSES (Section to be filled out only if applicable.)

In all cases, please submit original receipts for air transportation including copy of boarding pass.

Claim for:

☐ **Death** (please submit death certificate or medical report indicating cause of death – Quebec residents: SP3 form is required)

☐ **Hospitalization** (please submit medical certificate indicating diagnosis, admission and discharge dates)

☐ **Disaster** at your principal residence/place of business (please submit substantiating documentation such as police report/private insurance confirmation)

Amount claimed for air transportation: $ _____

_____ _____ _____

Name of the immediate family member | Date of birth | Relationship to you

_____

Complete address of that person

_____ _____ _____

Hospital admission date | Hospital discharge date | Reason of admission

_____ _____ _____

Date of death | Cause of death | Place of death

In the 6 months prior to your departure date, was the person:

Hospitalized? ☐ YES ☐ NO If YES, please indicate dates and name of hospital: _____

Suffering from a terminal illness? ☐ YES ☐ NO

Residing in a long term care facility (CHSLD)/assisted living facility? ☐ YES ☐ NO

If YES, please indicate name and complete address of that facility: _____

CERTIFICATION AND AUTHORIZATION

I hereby assign to Tour+Med - 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.

Insured's signature: _____ Date: _____

Alberta Government

Insurance Claim Consent and Authorization

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, _____ hereby assign to _____

Name of Patient — Name of Payee

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

Effective Date

This consent is effective From _____ (Departure date)

Date *(yyyy-mm-dd)*

To _____ (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.

Date *(yyyy-mm-dd)*

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.