# 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: _____

## RESIDENTS OF ONTARIO : Ontario Health Insurance Plan (OHIP) Authorization and Release Section

**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 LS Travel Insurance Company directly and I hereby release OHIP, upon payment to LS Travel Insurance Company from any further claim or cause of action in connection therewith.

**2- CONSENT**

O **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 LS Travel Insurance Company, 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 LS Travel Insurance Company.

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.

O **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 substitude 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 LS Travel Insurance Company, 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 LS Travel Insurance Company.

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**

**_____**
**Address**

**_____/_____**
**Home Tel. Number / Work Tel. Number**

**_____**
**OHIP CARD # Version code**

**_____/_____**
**Signature Date D/M/Y**

**_____**
**WITNESS NAME**

**_____**
**Address**

**_____/_____**
**Home Tel. Number / Work Tel. Number**

**_____/_____**
**Signature Date D/M/Y**