WWW.TOURMED.CA
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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

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