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

_____ 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: _____

Régie de l'assurance maladie Québec

APPLICATION FOR REIMBURSEMENT

Before completing this form, read the reverse side and refer to the information on our website at **www.ramq.gouv.qc.ca**. Click on **Temporary stays outside Québec** under Citizens.

FOR OFFICE USE

CHECK THE APPROPRIATE BOX Healthcare services received: ☐ in Canada ☐ outside Canada

APPLICANT'S IDENTITY

HEALTH INSURANCE NUMBER	LAST NAME	LAST NAME AT BIRTH (IF DIFFERENT FROM THE NAME ON THE HEALTH INSURANCE CARD)
LETTERS / NUMBERS	FIRST NAME	DATE OF BIRTH (YEAR / MONTH / DAY) — SEX M ☐ F ☐

HOME ADDRESS (see over)

NO. / STREET / APT. / MUNICIPALITY

PROVINCE / POSTAL CODE / PHONE NUMBER AT HOME AREA CODE / PHONE NUMBER AT WORK AREA CODE

PERIODS OF TIME SPENT OUTSIDE QUÉBEC

Period during which you received healthcare services

Date of departure from Québec (Year / Month / Day)

Date of return to Québec ☐ ACTUEL DATE ☐ PLANNED DATE (Year / Month / Day)

If you spent other periods of **more than 21 consecutive days** outside Québec during the calendar year (January 1 to December 31), please specify:

REASON FOR SPENDING TIME OUTSIDE QUÉBEC (CHECK ONE BOX ONLY)

- ☐ **Vacation or seasonal absence**
- ☐ **Work** — Employer's name
- ☐ **Studies** — Attach a written attestation from the educational institution showing the beginning and end dates of your courses, unless you have already done so.
- ☐ **Receipt of healthcare not available in Québec** — Régie's authorization number
- ☐ **Permanent move outside Québec** — Date of move (Year / Month / Day)
- ☐ **Other** — Specify

1st PERIOD					
Date of departure			Date of return		
Year	Month	Day	Year	Month	Day

2nd PERIOD					
Date of departure			Date of return		
Year	Month	Day	Year	Month	Day

3rd PERIOD					
Date of departure			Date of return		
Year	Month	Day	Year	Month	Day

HEALTHCARE SERVICES RECEIVED

Give the reason for which you received these healthcare services

IN THE CASE OF AN ACCIDENT, SPECIFY THE TYPE OF ACCIDENT ☐ Automobile ☐ Work ☐ Other (specify) — Date of accident (Year / Month / Day)

Describe the services received (examinations, x-rays, surgery, etc.). If you need more space, use a separate sheet.

WHERE DID YOU RECEIVE THESE SERVICES?

MUNICIPALITY / CANADIAN Pprovince OR U.S. STATE / COUNTRY

If applicable, indicate the number of days you were hospitalized:

REIMBURSEMENT

Amount claimed — Canadian dollars ☐ Other currency ☐ SPECIFY:

Have you paid the bills? ☐ No ☐ Yes ☐ In full ☐ In part

AMOUNT PAID **(enclose originals of receipts)**

TRAVEL INSURANCE

Were you covered by travel insurance when you received the services?

☐ No ☐ Yes — NAME OF INSURANCE COMPANY

POLICY NUMBER

SIGNATURE AND AUTHORIZATION

☐ I hereby authorize the Régie de l'assurance maladie du Québec to provide to and receive from my travel insurance company all the information and documents required for the assessment and payment of my claims for insured medical and hospital services that I received and, if applicable, that my spouse or children received (family insurance).

☐ I hereby declare, knowing that this declaration has the same value as though it were made under oath in accordance with the *Canada Evidence Act*, that the above information is accurate. I authorize the Régie to request from the health professional or facility any additional information that it may require. If this information is not provided free of charge, I agree to it being obtained at my expense.

If my application results from an automobile accident or a work accident, I authorize the RAMQ to provide the SAAQ or the CNESST with a copy of any documents I may send to or receive from the Régie.

NAME OF PERSON SIGNING THIS FORM, IF OTHER THAN THE APPLICANT / RELATIONSHIP TO APPLICANT (FATHER, MOTHER, SPOUSE, GUARDIAN ETC.) / **SIGNATURE** X / YEAR / MONTH / DAY

1896 266 16/09

SEND TO:

LS-TRAVEL
247, Thibeau Blvd
Trois-Rivières (Quebec)
G8T 6X9

POWER OF ATTORNEY

I, the undersigned _____
(BLOCK LETTERS)

Empower LS-Travel:

1. To submit to the Régie de l'assurance-maladie du Québec (the Régie), in accordance with the laws and regulations applied by the Régie, my claims for the insured medical and hospital services which I, my spouse or my children received (family insurance)

in _____
LOCATION

during our stay from _____ to _____
DATE (YYYY-MM-DD) DATE (YYYY-MM-DD)

2. To transmit to and receive from the Régie all information and documents required for the assessment and payment of the said claims.

3. To receive from the Régie all amounts reimbursed and due to me, my spouse or my children (family insurance).

I AUTHORIZE the Régie to accept the claims submitted, to act in accordance with this Power of Attorney as specified and to transmit to LS-Travel any information regarding the beneficiary status of myself, my spouse or my children.

_____ _____
SIGNATURE HEALTH INSURANCE NUMBER