



## 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.
- Make sure to provide legible documents. Photographs and pictures will not be accepted.

### 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](mailto:claimsfollowup@tourmed.ca)



**Group Out-of-Province Travel Medical Emergency Insurance**

**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 as soon as possible but no later than 90 days after your return in 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.
- **A proof\*** of your **Departure date** from your province of residence is mandatory.  
 (\* boarding pass, plane ticket, credit card receipt, confirmation obtained at the border/immigration).

**PARTICIPANT'S STATEMENT**

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

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First name \_\_\_\_\_ Last name \_\_\_\_\_ Contract Number \_\_\_\_\_

No. \_\_\_\_\_ Street \_\_\_\_\_ apt. # \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
dd mm yy

Government Health Insurance Number \_\_\_\_\_

Email Address: \_\_\_\_\_

Name of the employer: \_\_\_\_\_

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

Company : \_\_\_\_\_ Policy Number : \_\_\_\_\_ Telephone : ( \_\_\_\_\_ ) \_\_\_\_\_

**DEPENDANTS - to be completed if the claim is for a Dependant**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
dd mm yy Relationship with Participant: \_\_\_\_\_

Signature of the Dependant (if has reached age of majority) \_\_\_\_\_

If the claim is for a Dependant child:

Is he/she married? YES  NO  Does he/she usually live with the Participant? YES  NO

Is he/she a student in a Cegep (college) or university? YES  NO

If yes, name and address of the educational institution: \_\_\_\_\_

**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 (dd/mm/yy)	Amount billed	Amount paid by you	Currency
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	

**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) Have the expenses been incurred during a business trip?    YES     NO

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

e) 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.

\_\_\_\_\_

\_\_\_\_\_

f) Please provide name and contact information of your family doctor in Canada.

I don't have a family doctor

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

**CERTIFICATION AND AUTHORIZATION**

I hereby assign to LS-Travel, Insurance Company, (hereinafter "Insurer") any benefits obtained from other sources, including but not limited to, insurance companies, airlines, travel agencies, and any other source, for losses covered under this policy. I also direct these sources to transmit payment to the Insurer for my claims submitted by the *Insurer* with regard to these losses and authorize all sources and the *Insurer* to communicate all relevant information to facilitate the claims process.

I hereby authorize LS-Travel, Insurance Company, to collect, by any electronic means, email, fax or mail, and to use, any medical or non-medical information about me held by, including but not limited to, any licensed physician, practitioner, hospital or medical institution, insurance company, or any other organization, agency, institution, company or person (hereinafter "Third Parties") who has information or documents relevant to the analysis of any claim submitted under this insurance policy. I understand that this information could also be communicated to these Third Parties, whether in or outside of my province of residence.

If, for any reason, I do not authorize LS-Travel, Insurance Company, to collect and use this information, I understand that my benefits could be reduced or limited, according to the terms and conditions of the policy. A photocopy or facsimile of this authorization is accepted and recognized as valid as the original or a true copy thereof.

I declare that I am aware of the rights granted by the "Act Respecting the Protection of Personal Information in the Private Sector", including but not limited to the right to access my information, the right to have that information corrected, if need be, and the right to withdraw, at any time, this authorization to share and use my personal information.

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 statements 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 accurate 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 or a true copy thereof.

**Signature of the claimant spouse (if applicable):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of the Participant:** \_\_\_\_\_ **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 substitute 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

\_\_\_\_\_  
WITNESS NAME

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_/\_\_\_\_\_  
Home Tel. Number / Work Tel. Number

\_\_\_\_\_/\_\_\_\_\_  
Home Tel. Number / Work Tel. Number

\_\_\_\_\_  
OHIP CARD #

\_\_\_\_\_  
Version code

\_\_\_\_\_  
Signature

\_\_\_\_\_/\_\_\_\_\_  
Date D/M/Y

\_\_\_\_\_/\_\_\_\_\_  
Signature

\_\_\_\_\_/\_\_\_\_\_  
Date D/M/Y