

Section 1 - Claimant Information (Please print)

Last Name:

First Name:

Date of Birth (M/D/Y):

Relationship to Policyholder:

If the claimant is a child over 21 years, are they a full-time student?:

No

Yes

If yes, hours per week:

If employed, how many hours worked per week?

Does claimant reside with policyholder?

No

Yes

Provincial Health Card Number:

Version Code (Ontario residents, if applicable):

Address (Number, Street):

City:

Province:

Postal Code:

Phone Number:

Alternate Number:

Email:

Preferred Method of Communication (check all that apply)

Email

Phone

Mail

Section 2 - Policyholder Information (Please print)

Last Name:

First Name:

Date of Birth (M/D/Y):

Policy Number / Employee ID Number:

Group /Employer Name (if applicable):

Address (Number, Street):

City:

Province:

Postal Code:

Phone Number:

Alternate Number:

Email:

Section 3 - Travel Details

Travel Destination:

Departure Date (M/D/Y):

Return Date (M/D/Y):

Section 4 - Medical Information about the Claimant

Please describe briefly why medical attention was sought:

When did the symptoms first appear? (M/D/Y):

When did you first seek treatment? (M/D/Y):

Name of Medical Facility where you consulted:

Telephone number of Medical Facility:

Out of Country/Travel Assistance Claim Form

Claim Number:

Section 5 - Other Insurance

If, at the time of loss, you have similar coverage with another provider (i.e. credit card, travel insurer, employment group plan, etc.), we will coordinate benefits in accordance with the CLHIA guidelines.

Do you, your spouse or your child have other insurance coverage?

No

Yes

If yes, please complete the following sections that apply to you.

Employer, Retiree or Other Group Plan

Name of the Insurance Company:

Policy No./Certificate No.:

ID No./Plan No.:

Primary Policyholder Name:

Date of Birth (M/D/Y):

Credit Card Coverage

Issuing Bank:

Card Number (First 6 digits):

Card Number (Last 4 digits):

Other Coverage

Name of the Insurance Company:

Policy No. / Certificate No.:

Primary Policyholder Name:

Date of Birth (M/D/Y):

U.S. Medicare:

No

Yes

Type A

Type B

Both

Enrollment Number

If you have claimed from any other insurer, please provide your claim number and attach a copy of your claim and the settlement if available.

Section 6 - Declaration/Authorization/Signature

The Canada Life Assurance Company ("the Insurer") has appointed Global Excel Management Inc. ("Global Excel") as the provider of Travel Assistance and Out of Country claims services under this policy.

The Insurer, its Agents and Administrators are obliged to collect and retain certain personal information and/or health information about *you* in connection with *your* insurance coverage. They use and disclose that information only for the purposes of administering *your* policy/policies of insurance, providing customer service and assessing and paying claims. *You* and *your* mean the policyholder and/or the claimant, as applicable.

If the claimant is your minor child, you are also signing this form on their behalf.

- I direct and authorize my provincial government health insurance plan (GHIP) to make a payment in respect of my claim to Global Excel directly and I hereby release GHIP, upon payment to Global Excel from any further claim or cause of action in connection herewith.
- I hereby consent and authorize GHIP to directly or indirectly collect and use personal information including personal health information related to payment of my claim.
- I authorize Global Excel to coordinate the payment of benefits with any other insurance carriers which may also have a liability for this claim. I hereby irrevocably direct Global Excel, to make any payments, receive payments and settle with other carriers on my behalf.
- I authorize any other insurance carrier to release and exchange with Global Excel or its representatives any medical or benefits payment information relating to this claim.
- I authorize Global Excel, including its representatives, to disclose to the Insurer any information relating to this claim that it may have in its possession including information it obtains from third parties. I am aware that any authorization I provide to Global Excel to obtain information about this claim from any third party is also an authorization for the Insurer to obtain copies of the information.
- I consent to Global Excel communicating with me via electronic means regarding my claim at the email address I have provided, and understand that this communication will contain personal information.
- I authorize any licensed physician, medical practitioner, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, provincial health insurance plan and employer(s) to provide Global Excel, and its representatives employed to assist in the administration of the claim, any information, including personal information, data or records that are in their possession/knowledge regarding my medical history and treatment.
- I understand that if I am a dependent under this insurance coverage, the named policyholder will have access to information related to this claim in connection with the administration of this plan.
- I hereby consent to the use by Global Excel, its Agents and Administrators of the personal and health information about me disclosed herein and in all documents or information provided in connection with my insurance coverage for the purposes cited above. This consent is effective for two years from the date of services provided and I may revoke this consent in writing at any time by advising Global Excel.
- A photocopy of this authorization shall be considered as effective and valid as the original.
- **Notice:** The provincial legislation in some provinces requires us to inform you that the time limit for taking legal action is set out in the Insurance Act or other legislation that applies to your claim.
- **IMPORTANT:** Any reference to testing, tests, test results, or investigations excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.
- I authorize Global Excel to make payment directly to the providers of service and to deposit all personal claim payments directly to the account indicated on this form.
- I certify that the information I provided is true and correct to the best of my knowledge. I understand that this claim shall be void if, whether before or after the loss, I concealed or misrepresented any facts, or if any documents received regarding this claim have concealed or misrepresented any fact or circumstances concerning this claim.

Claimant Name:

Claimant Signature:

Date (M/D/Y):

If I am not the Claimant:

- **Use this section if you are completing the claim form on behalf of someone else.**
- In providing this authorization to collect personal information about the Claimant relating to this claim, I the undersigned do hereby certify that I have appropriate permission from the Claimant to authorize the collection, use and disclosure of their personal information as authorized above and that the Insurer and its agents and reinsurers may rely and act upon my authorization.

Authorized Person's Name:

Relationship to the Claimant:

Authorized Person's Address:

Authorized Person's Signature:

Date (M/D/Y):

Global Excel Management Inc. ("Global Excel") is the authorized administrator of this coverage. The Canada Life Assurance Company has appointed Global Excel as the provider of Travel Assistance and Out of Country claims services under this policy. Out of Country/Travel Assistance coverage is underwritten by The Canada Life Assurance Company. All trademarks are the property of their respective owners. Canada Life and design are trademarks of The Canada Life Assurance Company and used under license.

Section 7 - Incurred Expense List

No.	Name of Clinic, Doctor, Dentist, Hospital, Pharmacy	Description of Expense	Date M/D/Y	Amount Billed	Amount Paid	Outstanding Balance	Currency	Receipt included (check the appropriate box)
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1. No Yes

2. No Yes

3. No Yes

4. No Yes

5. No Yes

Comments:

Clearly indicate which invoice(s) have been paid. Keep a copy of this form (as well as copies of all supporting documents) for your records.

The processing of your claim will be delayed for any of the following reasons:

- A delay in receiving medical information from your treating doctor or physician in Canada.
- A delay in receiving medical records from the treating facility at your travel destination.
- An incomplete claim form.
- Insufficient (or incorrect) supporting documentation.

It is possible that you could receive invoices or reminder notices directly from the health care providers you consulted while travelling. Should this occur, please forward these notices to Global Excel.

Should you receive any phone calls regarding your invoices, please direct the caller(s) to Global Excel.

We request that you not pay any medical accounts directly to providers, unless you have been advised to do so by Global Excel.

Section 8 - Preferred Method of Reimbursement

Please visit www.globalexcel.com/canadalife to log in or register to our secure claimant portal and choose your preferred method of reimbursement. You can also change your method of reimbursement by completing this section.

IMPORTANT: If a method of reimbursement is not selected or exceeds the limit of the method chosen, a cheque will be issued for eligible reimbursements.

Interac e-transfer (CAD only)

By providing your email address, you will receive an email notification once your claim is settled. You may then directly deposit your reimbursement to the online banking platform of your choice.

Email address:

Direct deposit (CAD only)

By providing your banking information, your claim payments will be deposited directly to your account and you will get an email notification when your claim is settled.

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Transit Number (5 digits):	Institution number (3 digits):	Account Number (12 digits):

Cheque