ONEWORLD ASSIST

DOCUMENTATION REQUIREMENTS

EMERGENCY MEDICAL CLAIMS FOR TRAVELLING CANADIANS ALBERTA RESIDENTS

Below is a list of required claim forms and additional information, needed to process your recent claim. Please review each item carefully and complete it as accurately and as fully as possible. Be sure to sign each form as indicated. In addition, provide all ORIGINAL receipts, bills and/or prescription receipts.

- ☑ **Excess Hospital-Medical Claim**
  - Please complete both sides of this form.
  - In Section 3, please remember to sign the bottom of this section, warranting you have disclosed all additional coverages. (Reminder: if information is incomplete or inaccurate, your claim may be null and void)
  - If you list additional coverage in Section 3, you must also sign Section 4.

- ☑ **Consent to the Release of Individually Identifying Health Information to a Secondary Insurer form**
  - This form is required for the Alberta Health Care Insurance Plan.
  - Do NOT complete the top two sections—we will fill in the dates for you. You only need to have the form signed AND witnessed.
  - This form is not required if you are ONLY claiming for any of the following*:
    - Treatment provided by: a chiropractor, physiotherapist, chiropodist, osteopath, podiatrist, acupuncturist, naturopath, holistic doctor, or
    - Prescription glasses replacement, or
    - Additional air travel related benefits, or
    - Medical expenses incurred within Canada (other than in Quebec).

    *Not all policies cover all these benefits—refer to your policy wording to determine if these are covered by your policy.

- ☑ **All ORIGINAL, itemized bills/receipts.**

- ☑ **All ORIGINAL prescription drug receipts** (pharmacy issued tax or customer receipts).

- ☑ **Proof of payment**
  - If you have already paid the medical provider or facility directly, please provide proof of the amount paid so we can process your reimbursement.
  - For example, “paid” receipt from the provider, credit card statement, copy of a cancelled cheque, etc.

- ☑ **Written statement (if your claim is related to an ILLNESS)**
  - Please provide a written statement detailing the diagnosis or the nature of the illness you are claiming for.
  - Wherever possible, please include the dates and times of your consultations, and the name, address and telephone number of the physician/facility that treated you.

- ☑ **Written statement (if your claim is related to an INJURY)**
  - Please provide a written description of the event which caused your injury. Be sure to include the date and time of the incident as well as the name, address and telephone number of who you feel is responsible.
  - If possible, please also include the name, address and telephone number of the physician/facility that treated you for the injury.

In the unfortunate event you are filing a claim for someone who has passed away, please also submit:

- ☑ A copy of the Insured’s Death Certificate.

- ☑ A copy of the section of the Will which designates who will be acting on behalf of the Estate (i.e. who is the Executor).

- ☑ The original receipts for cremation or for homeward carriage for burial, if these expenses were incurred while the Insured was travelling.

As we are unable to process your claim until this information is received, please provide all of the requested information as soon as possible.

Thanks for your assistance.

OneWorld Assist looks forward to resolving your claim.

ONEWORLD ASSIST

This form will be returned if not completed in full

10th Floor, 6081 No. 3 Road • Richmond, BC V6Y 2B2
Telephone: 604 278 4108 • Fax: 604 276 4593
Canada & USA Toll Free: 1 800 663 0399

Excess Hospital-Medical Claim

Claim No. _____

Important Reminders:

- Complete all sections of the claim form(s) in full (front and back), signing where indicated.
- Include original, itemized bills, indicating dates and costs of all services provided.
- Keep copies of all bills for your records.
- By submitting this claim form, you warrant that all information provided is true, correct and complete.
- Your provincial health plan is your primary coverage. Most provincial plans have a 90-day deadline for claiming; if you fail to meet the submission deadline for your provincial plan, you will be responsible for the amount that your provincial plan would have paid.

1. GENERAL INFORMATION

Name of the Insured claiming _____ FIRST NAME _____ FAMILY NAME _____ ❍ M ❍ F

Policy number _____ Date of birth _____ M | D | Y

Address _____ City _____ Prov. _____

Postal code _____ Telephone: Home [ ] _____ Office [ ] _____

E-mail address _____ Fax [ ] _____

Name of provincial health care plan and Personal Health Number _____

Name, address and telephone number of your usual Canadian physician _____

_____

State the names of <u>any</u> medications you were taking prior to departure _____

_____

Departure date from home province _____ M | D | Y Return date to home province _____ M | D | Y

Country where claim occured _____ Currency paid _____

Date Sickness or Injury occurred _____ M | D | Y

Nature and description of Sickness or Injury claimed _____

_____

2. MEDICAL AUTHORITY

AUTHORIZATION TO PHYSICIANS, HOSPITALS AND OTHER MEDICAL PROVIDERS

(This form will be returned to the sender if not completed and signed as indicated.)

1. I authorize all hospitals, physicians, medical care providers, insurers and other persons, from all countries, to provide to OneWorld Assist Inc. ("OWA") all information and documentation in their possession that OWA requires to process my claim, including: records in regard to illnesses, injuries, medical history, consultations, medicines and treatments of the claimant named below (collectively, the "Medical Records").
2. I authorize OWA to collect, use and disclose the Medical Records, and the information in the Medical Records, to the selling agent, and to any insurers, including government health plans, that may have a responsibility in this claim.
3. I understand that the purpose for the collection, use and disclosure of the Medical Records is to enable OWA and insurers to assess and determine the eligibility of any claim I might submit. I acknowledge and agree that it is my responsibility to provide to OWA such information and other documentation as may reasonably be required to process my claim and that my failure to do so will jeopardize my entitlement to coverage.
4. I understand that if Medical Records are required from the U.S., this purpose constitutes a payment operation under the privacy rules in the U.S. Health Insurance Portability and Accountability Act (HIPAA).
5. This authorization takes effect on the date set out below. I understand that I may revoke this authorization in writing. I acknowledge and agree that if this authorization is revoked before the Medical Records are collected and reviewed my entitlement to insurance coverage will be jeopardized.

A copy of this authorization received from OWA shall be as effective and valid as the original.

X _____
Signature **(Claimant or authorized representative)**

_____ FIRST NAME _____ FAMILY NAME
name **(and relationship if not claiment)**

M | D | Y
Date

PLEASE COMPLETE AND SIGN REVERSE SIDE

3. OTHER INSURANCE (If claimant is a dependent, provide requested information for parents or guardians.)

Do you have any group benefits available for medical coverage through your employer, your spouse's employer or a retirement plan? ___ Yes ___ No
If "Yes", please provide details below:

	Name of Insurance Co.	Telephone #	Group Policy#	Member ID#	Lifetime limit
Your employer/retirement plan					$
Spouse employer/retirement plan					$

Spouse's name _____FIRST NAME_____FAMILY NAME_____ Spouse's date of birth ___M___|___D___|___Y___

Do you have benefits available through any other travel insurance company or travel supplier? ____ Yes ____No If "Yes", please provide:

Name of other provider _____ Policy #_____

Address of other provider _____

Did you use a credit card for any of your travel arrangements? (many credit cards offer travel benefits) ____ Yes ____ No If "Yes", please provide:

Name of issuing financial institution _____

Card number _____ Expiry date _____

___FIRST NAME_____FAMILY NAME_____ **X** _____ ___M___|___D___|___Y___
Name of cardholder (please print) Cardholder signature (if different from insured) Date

I warrant that I do not have any other travel or out-of-country medical insurance coverage.

X _____ FIRST NAME_____FAMILY NAME_____ ___M___|___D___|___Y___
Signature (claimant or authorized representative) Print name Date

4. CLAIMANT'S ASSIGNMENT OF PAYMENT

I assign to OneWorld Assist Inc. ("OWA") any benefits obtainable from other sources for covered losses. For payments made on my behalf, I authorize any other carriers to assign eligible benefits to OWA.

A copy of this authorization received from OWA shall be as effective and valid as the original.

___FIRST NAME_____FAMILY NAME_____
Print full name (and relationship if not claimant)

X_____ _____M___|___D___|___Y_____
Signature (claimant or authorized representative) Date

X_____ _____M___|___D___|___Y_____
Signature of primary policy holder of other insurance in Section 3 above (if applicable) Date

Alberta Health and Wellness

Consent to the Release of Individually Identifying Health Information to a Secondary Insurer

Claims and Professional/Facility Management Branch
10025 Jasper Avenue NW
PO Box 1360 Station Main
Edmonton AB T5J 2N3

Note: Alberta Health and Wellness will not accept incomplete consent forms.

Authorization for release of information

I hereby authorize the Minister and the Department of Alberta Health and Wellness to disclose the following individually identifying health information in order to reimburse health benefits paid on my behalf by another insurance company in respect of health services received outside of Alberta:

- date(s) of service(s)
- type(s) of service(s)
- name(s) of service provider(s)
- amount(s) paid, and
- amount of any arrears I may owe to Alberta Health and Wellness for unpaid health insurance premiums

for _____, personal health number (PHN)_____,
(name of resident - please print) *(PHN of resident)*

from the _____ day of _____ , _____ to the _____ day of _____ , _____ .
(day) *(month)* *(year)* *(day)* *(month)* *(year)*

This information can be released to:

OneWorld Assist Inc.
(name of insurance company to which Alberta Health and Wellness is to release information)

Failure to authorize disclosure means Alberta Health and Wellness will not reimburse for health benefits received.

I understand why I have been asked to authorize disclosure of this information and I am aware of the risks and benefits of consenting, or refusing to consent to the disclosure.

Effective date

This consent is effective from:

the _____ day of _____ , _____ to the _____ day of _____ , _____ and may be revoked
(day) *(month)* *(year)* *(day)* *(month)* *(year)*
by me (in writing) at any time.

Authorization of payment

I assign to OneWorld Assist Inc. whatever benefits may be payable to me or on my behalf
(name of insurer)
for health services obtained outside Alberta. I further authorize Alberta Health and Wellness to deduct from the sums so payable any amount for which I may be indebted to Alberta Health and Wellness for arrears of health insurance premiums owing under the *Health Insurance Premiums Act*.

Signatures

_____
Signature of person completing request *(if 18 years of age or over)* - or -
Signature of authorized representative *(if person completing request is under 18 years of age or wholly dependent on the authorized representative by reason of mental or physical infirmity)*

_____
Signature of witness

_____
Name of person signing above
(Resident or authorized representative) (please print)

_____
Name of witness *(please print)*

_____
If signed by an authorized representative, please provide copies of legal documentation authorizing you to consent on the resident's behalf
(e.g. legal guardian, power of attorney, etc.)