Let's get started! We're looking forward to helping you with your claim.

Below is the list of required documents and additional information to finalize your claim. Be sure to review each item carefully and complete it as accurately as possible.

It's best to submit your claim forms to us within 60 days from the date the claim was opened—the sooner we receive your completed claim forms, the faster we can start processing your claim.

Here's what we'll need:

- **Excess Hospital/Medical Claim Form**
  - Complete both sides.
  - Sign the bottom of Section 3 to guarantee you have disclosed all additional coverage. Please note: if information is incomplete or inaccurate, we will not be able to process your claim.
  - If you list additional coverage in Section 3, be sure to also sign Section 4.
  - If someone is signing on your behalf, be sure to include a copy of the Power of Attorney to show that they are legally authorized to do so.

- **Schedule A**
  - Complete and sign Schedule A, required for Health Insurance BC.
  - If you make any changes, be sure to initial them.
  - If you are *only* claiming any of the following, this form is not required:
    - Treatment provided by: a chiropractor, physiotherapist, chiropodist, osteopath, podiatrist, acupuncturist, naturopath, holistic doctor
    - Prescription glasses replacement
    - Additional air travel related benefits
    - Medical expenses incurred within Canada (other than in Quebec)

(Not all policies cover the above benefits—refer to your policy wording to check your coverage.)

- **All original, itemized bills and receipts**

- **All original prescription drug receipts**
  - Be sure they are the official tax receipts and not credit card or till receipts.

- **Out-of-Country Claim Form** (If hospitalized overnight, this form is required by Health Insurance BC)
  - Complete and sign Section A only, including the Release of Information at the bottom of the section.
  - If the claim is due to an injury or a motor vehicle accident, complete the applicable portions of Section C.
  - If you were not hospitalized overnight, this form is not required.

- **Proof of payment**
  - If you have already paid the medical provider or facility directly, provide proof of the amount paid so we can process your reimbursement.
  - This could be a receipt marked “paid” from the provider, a credit card statement, or a copy of a cancelled cheque.
  - If you paid by credit card, you may want to include a copy of the credit card statement showing the exchange rate and amount charged in Canadian dollars.

- **Written description (if your claim is related to an illness)**
  - Describe the diagnosis, symptoms, or the nature of the illness you are claiming for.

- **Written description (if your claim is related to an injury)**
  - Describe the injury and tell us how it happened.
  - Be sure to include the date and time of the incident as well as the name, phone number and email address (if possible) of the person or company you feel is responsible.

(If you need more space than what is provided on the claim form, feel free to write the above information on a separate piece of paper—any format is fine.)

In the unfortunate event that 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 indicating who is legally authorized to act on behalf of the Estate.

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

If you have any questions, feel free to call us toll free at 1-800-663-0399 or collect at 604-278-4108. You can also email us at claims@tugo.com.

We look forward to completing your claim as quickly as possible.

Take care,

Claims at TuGo

Excess Hospital-Medical Claim

Claims at TuGo, 10th Floor, 6081 No.3 Road
Richmond, BC Canada V6Y 2B2

Tel: 604-278-4108 **Fax:** 604-276-4593
Canada & USA Toll Free: 1-800-663-0399

Claim No.

For office use only

(Please print clearly. This form will be returned if not completed in full.)

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 LAST NAME ○ M ○ F

Policy number _____ Date of birth MM | DD | YYYY

Address _____

City _____ Prov. _____ Postal code _____

Telephone Home ( ) _____ Office ( ) _____

Email _____ 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 any medications you were taking prior to departure _____

Departure date from home province MM | DD | YYYY Return date to home province MM | DD | YYYY

Country where claim occured _____ Currency paid _____

Date Sickness or Injury occurred MM | DD | YYYY

Nature and description of Sickness or Injury claimed _____

2. MEDICAL AUTHORITY

Authorization to physicians, hospitals, other medical providers & other insurers

1. I authorize all hospitals, physicians, medical care providers, insurers and other persons, from all countries, to provide to **Claims at** TuGo all information and documentation in their possession that **Claims at** TuGo 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") and other applicable insurance policy information.
2. I authorize **Claims at** TuGo 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 and other insurance policy information is to enable **Claims at** TuGo and insurers to assess and determine the eligibility of and other available insurance for any claim I might submit. I acknowledge and agree that it is my responsibility to provide to **Claims at** TuGo 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.
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 **Claims at** TuGo shall be as effective and valid as the original.

FIRST NAME LAST NAME
Print name (and relationship if not claimant)

X _____
Signature (Claimant or authorized representative)

MM | DD | YYYY
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					$
Spous'e employer/retirement plan					$

Spouse's name FIRST NAME LAST NAME Spouse's date of birth MM | DD | YYYY

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 _____

FIRST NAME LAST NAME
Name of cardholder (please print)

X _____
Cardholder signature (if different from insured)

MM | DD | YYYY
Date

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

X _____
Signature (claimant or authorized representative)

FIRST NAME LAST NAME
(Print name)

MM | DD | YYYY
Date

4. CLAIMANT'S ASSIGNMENT OF PAYMENT

I assign to **Claims at** TuGo 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 **Claims at** TuGo.

A copy of this authorization received from **Claims at** TuGo shall be as effective and valid as the original.

FIRST NAME LAST NAME
Print name (and relationship if not claimant)

X _____
Signature (claimant or authorized representative)

MM | DD | YYYY
Date

X _____
Signature of primary policy holder of other insurance in Section 3 above (if applicable)

MM | DD | YYYY
Date

BC Residents Only

For faster claim service, please complete and SIGN this form and send it with the completed Claim Form and your original bills/receipts to:

Claims at TuGo, 10th Floor, 6081 No.3 Road
Richmond, BC Canada V6Y 2B2

Tel: 604-278-4108 **Fax:** 604-276-4593
Canada & USA Toll Free: 1-800-663-0399

BRITISH COLUMBIA | Health InsuranceBC
The Best Place on Earth

Schedule A

ASSIGNMENT OF PAYMENT

Personal Health (CareCard) Number of Patient: _____

BETWEEN: _____
Assignor (Adult Patient or Parent/Guardian of Patient)

AND: **Claims at** TuGo
10th Floor - 6081 No. 3 Road
Richmond, BC V6Y 2B2

AND: HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF BRITISH COLUMBIA AS REPRESENTED BY THE MINISTER OF HEALTH SERVICES, hereinafter referred to as the Minister.

WHEREAS the Assignor is a person eligible for insured services and/or benefits under the Province of *British Columbia's Medicare Protection Act and/or Hospital Insurance Act*, and as such may receive payment for certain of those services or benefits from the Minister.

And WHEREAS the Assignor is bound by an obligation under a contract or agreement with the Assignee to remit to the Assignee all payments received for such insured services and/or benefits from the Minister.

THEREFORE, in consideration of the obligation to the Assignee, the Assignor hereby assigns to the Assignee all sums of money that shall be owing to the Assignor by the Minister in relation to the insured services and/or benefits referred to above. The Minister is hereby authorized to pay all such sums directly to the Assignee at the address noted above, or at any address the Assignee may from time to time designate, with payment of any such sum to be a complete discharge of the Minister from any indebtedness in the amount to the Assignor, his heirs, executors, or administrators.

By signing this form, you will be assigning your MSP and hospital insurance benefit to the insurance company (Assignee) named above.

Payment assignment is effective dates (policy effective dates): from: MM | DD | YYYY to: MM | DD | YYYY

X _____
Signature of Assignor (Patient or Parent/Guardian of Patient)

MM | DD | YYYY
Date Signed

HealthInsuranceBC

Your connection with Medical Services Plan and PharmaCare.

OUT-OF-COUNTRY CLAIM FORM

Return to: Medical Services Plan
Out-of-Country Claims
PO Box 9480 Stn Prov Govt
Victoria BC V8W 9E7

IMPORTANT ➢ ***This form must be completed and signed by the patient or their legal guardian.***

➢ ***Refer to Section D on the back before completing this form***

➢ *Claims **must** be received **within 90 days** of the date of service*

➢ *Attach **all original receipts or bills** to this form. Include **itemized statement***

➢ *Retain copies of bills or receipts for your records*

➢ *Receipts not in English **must be translated** before being submitted*

➢ *Form **must be signed** by patient or legal guardian*

Personal information on this form is collected under the authority of the *Medicare Protection Act.* The information will be used to determine residency in BC and determine eligibility for provincial health care benefits. If you have any questions about the collection of this information, contact an MSP client representative at the address or telephone number shown in Section D of the form. Personal information is protected from unauthorized use and disclosure in accordance with the *Freedom of Information and Protection of Privacy Amendment Act* and may be disclosed only as provided by that Act.

SECTION A - PATIENT INFORMATION

PERSONAL HEALTH NUMBER (ON CARECARD)

DATE OF BIRTH *Month* *Year*

SEX ❒ MALE ❒ FEMALE

NAME OF PATIENT (FAMILY NAME) GIVEN NAMES

TELEPHONE NUMBER Home: Work:

POSTAL ADDRESS
Number and Street or Box No. City / Town Province Postal Code

RESIDENTIAL ADDRESS OF PATIENT *(if different from above)*
Number and Street or Box No. City / Town Province Postal Code

HAS PATIENT LIVED AT ABOVE ADDRESS 6 MONTHS PRECEDING DEPARTURE FROM B.C.? ❒ YES ❒ NO *If No, provide residential address(es) where patient was living*

Number and Street	City / Town	Province	Postal Code	From *Month* *Year*	To *Month* *Year*

NAME AND ADDRESS OF PRESENT OR LAST EMPLOYER IN BRITISH COLUMBIA OF ❒ PATIENT OR ❒ HEAD OF FAMILY *(Check appropriate box)*
Name Address

NAME OF A PERSON *(not a relative)* WHO CAN CONFIRM PATIENT'S RESIDENCE IN BRITISH COLUMBIA
Name *(in full)* Address *(include Postal Code)*

REASON FOR ABSENCE FROM BRITISH COLUMBIA

❒ VACATION ❒ OBTAIN MEDICAL CARE ❒ BUSINESS TRIP

❒ MOVED ❒ STUDENT ❒ OTHER *(specify):*

	Month	*Day*	*Year*
DATE OF DEPARTURE FROM B.C.			
DATE OF RETURN TO B.C.			

DO YOU HAVE EXTENDED HEALTH BENEFITS INSURANCE OR TRAVEL INSURANCE? ❒ YES ❒ NO

NAME OF COMPANY

POLICY NUMBER

ARE YOU OR ANY DEPENDENTS COVERED BY HEALTH INSURANCE IN ANOTHER COUNTRY? ❒ NO ❒ YES *If YES, attach statement of payment of claims.*

RELEASE OF INFORMATION

The information on this form is collected under the authority of the Medicare Protection Act and the Hospital Insurance Act

I _____ hereby authorize Out-of-Country Claims, Medical Services Plan, to obtain information
Name of patient
necessary for the processing of my claim from the Hospital and/or Doctor who provided care or in the event of an appeal on this case to provide the appeal board with the appropriate information in order for an informed decision to be made.

I also authorize Out-of-Country Claims, Medical Services Plan, to provide/obtain information to/from the above named travel insurance or extended health benefits company.

In addition, my signature below is my Application for Benefits under the Hospital Insurance Act of British Columbia (for in-patient hospital charges).

I certify that I am the person entitled to receive benefits and that all statements made by me are true and correct .

X _____ _____
Patient/Legal Guardian Signature *Date*

SECTION B - TO CLAIM FOR DOCTOR'S FEE COMPLETE THIS SECTION

THE REASON FOR SEEKING MEDICAL ATTENTION (DIAGNOSIS)

TREATMENT / PROCEDURE	**DURATION OF ANAESTHETIC** ________ Hrs. ________ Min. *or* From: To:
LABORATORY TESTS	CHARGE $
SPECIFY EACH AREA X-RAYED	CHARGE $

DOCTOR'S NAME AND SPECIALTY	DATE Month	Day	Year	TYPE OF VISIT	TIME OF VISIT	CHARGE	COUNTRY AND CURRENCY
				❒ Office ❒ Home ❒ Hospital	❒ 8 a.m. - 6 p.m. ❒ 6 p.m. - 11p.m. ❒ 11p.m. - 8 a.m.		

WERE YOU REFERRED BY ANOTHER DOCTOR? If so, please provide name and address

HAVE YOU PAID THE ACCOUNT? ❒ YES ❒ NO

DOCTOR'S NAME AND SPECIALTY	DATE Month	Day	Year	TYPE OF VISIT	TIME OF VISIT	CHARGE	COUNTRY AND CURRENCY
				❒ Office ❒ Home ❒ Hospital	❒ 8 a.m. - 6 p.m. ❒ 6 p.m. - 11p.m. ❒ 11p.m. - 8 a.m.		

WERE YOU REFERRED BY ANOTHER DOCTOR? If so, please provide name and address

HAVE YOU PAID THE ACCOUNT? ❒ YES ❒ NO

DOCTOR'S NAME AND SPECIALTY	DATE Month	Day	Year	TYPE OF VISIT	TIME OF VISIT	CHARGE	COUNTRY AND CURRENCY
				❒ Office ❒ Home ❒ Hospital	❒ 8 a.m. - 6 p.m. ❒ 6 p.m. - 11p.m. ❒ 11p.m. - 8 a.m.		

WERE YOU REFERRED BY ANOTHER DOCTOR? If so, please provide name and address

HAVE YOU PAID THE ACCOUNT? ❒ YES ❒ NO

DOCTOR'S NAME AND SPECIALTY	DATE Month	Day	Year	TYPE OF VISIT	TIME OF VISIT	CHARGE	COUNTRY AND CURRENCY
				❒ Office ❒ Home ❒ Hospital	❒ 8 a.m. - 6 p.m. ❒ 6 p.m. - 11p.m. ❒ 11p.m. - 8 a.m.		

WERE YOU REFERRED BY ANOTHER DOCTOR? If so, please provide name and address

HAVE YOU PAID THE ACCOUNT? ❒ YES ❒ NO

DOCTOR'S NAME AND SPECIALTY	DATE Month	Day	Year	TYPE OF VISIT	TIME OF VISIT	CHARGE	COUNTRY AND CURRENCY
				❒ Office ❒ Home ❒ Hospital	❒ 8 a.m. - 6 p.m. ❒ 6 p.m. - 11p.m. ❒ 11p.m. - 8 a.m.		

WERE YOU REFERRED BY ANOTHER DOCTOR? If so, please provide name and address

HAVE YOU PAID THE ACCOUNT? ❒ YES ❒ NO

DOCTOR'S NAME AND SPECIALTY	DATE Month	Day	Year	TYPE OF VISIT	TIME OF VISIT	CHARGE	COUNTRY AND CURRENCY
				❒ Office ❒ Home ❒ Hospital	❒ 8 a.m. - 6 p.m. ❒ 6 p.m. - 11p.m. ❒ 11p.m. - 8 a.m.		

WERE YOU REFERRED BY ANOTHER DOCTOR? If so, please provide name and address

HAVE YOU PAID THE ACCOUNT? ❒ YES ❒ NO

SECTION C - TO CLAIM FOR IN-PATIENT HOSPITAL CHARGES COMPLETE THIS SECTION

- *In-patient hospital charges include registered bed patient, dialysis, and surgical day care.*
- *Entitlement for hospital benefits is dependent upon residency and it is therefore essential that Sections A and C be completed in the fullest possible detail.*
- ***A separate application is required for each admission to hospital for which a claim is made.***
- *The information requested in this form refers specifically to the person hospitalized. In the case of a dependent child it is necessary to supply particulars of the residence of the head of family.*
- *If the condition of the person requiring admission to hospital does not permit him/her to apply on his/her own behalf, or if he/she is an underage dependent, this form should be completed by a member of the family or some other person having knowledge of the facts.*

NAME OF HOSPITAL

POSTAL ADDRESS OF HOSPITAL

DATE OF ADMISSION — *Month* / *Day* / *Year*

DATE OF DISCHARGE — *Month* / *Day* / *Year*

ADMITTING DIAGNOSIS (NATURE OF ILLNESS) AND TREATMENT PROVIDED DURING HOSPITALIZATION

HAVE YOU PAID THE HOSPITAL ACCOUNT? ❒ NO ❒ YES, *Enclose proof of payment*

WAS THIS ADMISSION TO HOSPITAL THE RESULT OF AN ACCIDENTAL INJURY? ❒ NO ❒ YES, *Complete the following*

DESCRIBE HOW ACCIDENT TOOK PLACE *(Give names of other persons involved and details of their insurance, if any)*

DATE OF ACCIDENT	ACCIDENT LOCATION	WHO DO YOU THINK WAS RESPONSIBLE FOR THE ACCIDENT?

WHERE HOSPITALIZATION IS THE RESULT OF A **MOTOR VEHICLE ACCIDENT,** COMPLETE THE FOLLOWING

IF **TWO-CAR** COLLISION GIVE:

A. FULL NAME AND ADDRESS OF **OTHER** DRIVER

NAME

ADDRESS

B. NAME AND ADDRESS OF OTHER DRIVER'S AUTOMOBILE INSURANCE COMPANY & POLICY NUMBER

NAME

ADDRESS

POLICY NUMBER

IF YOU WERE A **PEDESTRIAN** OR **CYCLIST** STRUCK BY AN AUTOMOBILE GIVE:

A. FULL NAME AND ADDRESS OF **OTHER** DRIVER

NAME

ADDRESS

B. NAME AND ADDRESS OF OTHER DRIVER'S AUTOMOBILE INSURANCE COMPANY & POLICY NUMBER

NAME

ADDRESS

POLICY NUMBER

IF YOU WERE IN AN AUTOMOBILE SHOW WHETHER YOU WERE ❒ DRIVER OR ❒ PASSENGER, IF PASSENGER GIVE:

A. FULL NAME AND ADDRESS OF **OTHER** DRIVER

NAME

ADDRESS

B. NAME AND ADDRESS OF OTHER DRIVER'S AUTOMOBILE INSURANCE COMPANY & POLICY NUMBER

NAME

ADDRESS

POLICY NUMBER

ICBC CLAIM NUMBER *(if applicable)*

SIGNATURE

X

Where a beneficiary receives in-patient hospital services for accidental injuries received as a result of the wrongful act or omission of some other person, the amount of benefits is reduced by the amount of any settlement or award received by the beneficiary in respect of the cost of such hospital services from the person alleged to have been responsible for causing the injuries.

SECTION D - GENERAL INFORMATION

The Medical Services Plan insures out of country medical services required on an emergency basis during a temporary absence and claims must be submitted **within 90 days** from the date of service.

The plan pays for medically required treatment by a qualified **Doctor (M.D.)** up to B.C. rates, any difference in fees is the patient's responsibility.

In-patient hospital benefits are provided to eligible British Columbia residents who are taken ill or are accidentally injured outside British Columbia.

Payment can be made directly to the doctor/hospital. The account holder will be reimbursed if the account has been paid. In instances where there is a small amount payable or the facility/doctor does not accept Canadian currency, payment is made to the patient. The patient is responsible for payment of the account.

Please allow 12-16 weeks for processing.

ELECTIVE SERVICES

If you wish to leave Canada specifically to obtain medical care, it is necessary for the BC attending specialist to write to MSP before you leave the province to request ***prior approval*** for payment of insured services. Please note that if approval is NOT received, all costs of such elective services will remain your responsibility. Travel costs and accommodation are not covered by MSP.

MSP DOES NOT PROVIDE COVERAGE FOR THE FOLLOWING:

- services that are not deemed to be medically required, such as cosmetic surgery
- dental services, except as outlined below
- routine eye examinations for persons 19 to 64 years of age
- eyeglasses, hearing aids, and other equipment or appliances
- annual or routine examinations where there is no medical need
- services of counsellors or psychologists
- certified physician assistant
- registered nurse/nurse practitioner
- prosthesis and appliances
- nurse anaesthetist
- care in health spas and similar facilities
- transportation and accommodation expenses
- supplies and materials
- use of emergency room, private clinic/surgical facility fees
- medical care at the request of a third party
- medical examinations, certificates or tests required for:
  - driving a motor vehicle
  - employment
  - life insurance
  - immigration purposes
  - school or university
  - recreational/sporting activities

MSP DOES NOT PROVIDE COVERAGE *OUTSIDE THE PROVINCE* FOR THE FOLLOWING:

- prescription drugs
- ambulance service
- massage therapy
- physical therapy
- naturopathy
- chiropractic
- podiatry

DENTAL AND ORAL SURGICAL PROCEDURES

Dental and Oral surgical procedures are included as benefits ***only*** when medically required to be performed in a hospital where the insured person is admitted as an in-patient or as a patient under Day Care Surgical services.

FOR FURTHER INFORMATION:

Health Insurance BC
Medical Services Plan
Out-of-Country Claims
PO Box 9480 Stn Prov Govt
Victoria BC V8W 9E7

Phone: 604 683-7151 Vancouver
1 800 663-7100 Toll-free (other areas in BC)
Fax: 250 405-3588

Web: www.hibc.gov.bc.ca (select Leaving British Columbia Information)

BEFORE MAILING: *Please ensure that all areas of the claim form are complete*
Attach all receipts or bills to this form. Include itemized statements
Ensure that you have signed all appropriate areas