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.

- **Authorization and Release Form**
  - This is required by the Ontario Ministry of Health and Long-Term Care (MOHLTC).
  - If your MOHLTC number has 2 letters at the end, include these as the Version code.
  - 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.

- **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

Authorization and Release

This form will be returned if not completed in full.

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

I, FIRST NAME LAST NAME irrevocably direct and authorize the Ontario Ministry of Health and Long-Term Care (MOHLTC) to make payment in respect of my claim for OHIP insured out-of-country health services to **Claims at** TuGo directly, and I hereby release and hold harmless the MOHLTC upon payment to **Claims at** TuGo of the amount payable under the Ontario Health Insurance Act from any claims or causes of action, present or future, in connection therewith and I further agree to indemnify MOHLTC with respect to any claim or action brought against it in respect of any such payments made by MOHLTC to **Claims at** TuGo.

I understand and acknowledge that information submitted by **Claims at** TuGo to MOHLTC with this claim is necessary for the administration of the Ontario Health Insurance Act including to process payment for my out-of-country services claim. I hereby consent and authorize MOHLTC to directly or indirectly collect this personal information, including personal health information, from **Claims at** TuGo for this purpose. I further consent to the disclosure by MOHLTC to **Claims at** TuGo of any personal information, including personal information, that in the opinion of MOHLTC is required for this purpose.

Ten-digit MOHLTC number

Version code

X

Signature of (or on behalf of) **Insured**

MM | DD | YYYY

Date