Manulife

MEDICAL INSURANCE CLAIM FORM FOR VISITORS TO CANADA

Policy No.: _____
Case No.: _____
Form No.: MLVTC012016E

The attached claim form must be completed in full, signed, and returned to our office as soon as possible. The receipt of your completed forms will enable us to begin the assessment of your claim.

HOW TO COMPLETE YOUR EMERGENCY MEDICAL INSURANCE CLAIM FORM

SECTION A – CLAIMANT INFORMATION

This section allows us to verify the claimant and policy information. If you contacted ACM to initiate your case, much of this section will be pre-populated. If necessary, please correct any inaccurate fields so that we may update our records.

Date of Arrival in Canada

This section is required to complete the review of your claim. ACM will accept a copy of a stamped passport, travel itineraries, airline tickets or boarding passes as evidence of your arrival date in Canada.

SECTION B – CERTIFICATION & AUTHORIZATION

This section must be completed in order to release payment of your claim. Completion certifies that the information provided in connection with this claim is complete, true and accurate.

This signed release allows us to access your personal medical information that is related to the claim. When necessary, it also allows us to obtain your past medical history from your treating physicians in Canada in order to validate the terms and conditions of your travel policy.

SECTION C – MEDICAL INFORMATION

This section provides a brief synopsis of the unexpected medical emergency.
If you were hurt, fill out the **Injury** section.
If you were sick, please complete the **Illness** section.

SECTION D – OTHER INSURANCE COVERAGE

This section allows us to coordinate medical payments with any other insurance plans that you may have in addition to this policy. Complete Section D if you have other out-of-country travel insurance such as an employer group benefit plan or coverage on your credit card.

SECTION E – EXPENSE SHEET

Please list all out of pocket expenses incurred and provide supporting documentation wherever possible. Please save copies of all original receipts and supporting documentation. ACM reserves the right to request original documentation when necessary to adjudicate your claim.

REQUIRED ATTACHMENTS

To process your claim, the following documents should be sent with your forms (please do not staple documents);

- ❑ If you paid any expenses yourself, please provide proof of payment by submitting all bills and receipts. Please complete the expense sheet (Section E). Itemized receipts are required. Credit/debit card transaction receipts or credit card/bank statements alone are insufficient.
  FOR PRESCRIPTION DRUGS: Official pharmacy receipts are required which must contain patient's name, date of service, drug name, quantity dispensed.
- ❑ All medical records, documents & certificates, provided at the time of treatment. This includes a diagnosis report, list of medication given and type of treatment provided. For example: a copy of the Emergency Room (ER) report, clinical documentation or a written letter from the doctor.
- ❑ If you were hospitalized, we require a copy of your medical records from the treating facility you attended.
- ❑ Proof of the date you arrived in Canada such as a copy of a stamped passport, travel itineraries, airline tickets or boarding passes
- ❑ If you have any additional information to support your claim, please submit.

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SUBMITTING YOUR CLAIM

- ❑ **By Mail:** All original forms, along with all documents noted above can be sent to our claims office:

Canadian Mailing Address	U.S.A. Mailing Address
Active Care Management **P.O. Box 1237** **Station A** **Windsor, ON N9A 6P8**	**Active Care Management** **535 Griswold Ave.** **Ste 111-605** **Detroit, MI 48226**

- ❑ **By Email:** Scanned copies of all completed & signed claims forms and applicable attachments can be submitted to ACM by email to **TravelClaims@Active-Care.ca**

Please save copies of all original claim forms, receipts and supporting documentation. ACM reserves the right to request original documentation when necessary to adjudicate your claim.

WHAT TO EXPECT DURING THE CLAIMS PROCESS

Once your completed claim package is received, your claim will go through the following stages:

1. Initial Review

Your documentation will be reviewed by our team for completeness and accuracy. This means we will be checking to ensure all the required documentation is included with your claim form. If required documentation is missing, you will be notified by ACM. When all required documentation is received, your claim will be assigned to a Claim Adjudicator who will begin the Evidence Review Stage.
Tip: Ensure that all sections of your claim form are fully completed, signed and dated. Submitting a complete claims package will ensure your claim is expedited through the Initial Review stage.

2. Evidence Review

During this stage, the Claim Adjudicator will review the details of the claim and identify if a decision can be made or if further clarification and collection of information is required. It is during this stage that past medical history, treatment notes or additional supporting evidence may be obtained. When all evidence is obtained, the claim will progress to the Decision Stage. *Tip:* You will be notified within 30 days if additional evidence is required.

3. Decision Stage

Once at this stage, the Claim Adjudicator will review all information collected, assess the claim under the insurance policy's terms and conditions and make a decision. For approved claims, you will be notified of the decision by receiving a cheque with an explanation of benefits. When a claim is denied, you will receive written correspondence from ACM. Payments by cheque are issued within three business days of approval decision and sent by standard Canadian mail.

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Your emergency medical insurance policy is underwritten by **The Manufacturers Life Insurance Company** ("Manulife"). Manulife has appointed Active Claims Management, Inc., operating as Active Care Management ("Agent" or "ACM"), as the provider of all assistance and claims services under the policy.

IMPORTANT: This claim form must be completed in full, signed, and returned to our office. The receipt of your completed forms will initiate the claims review process. The Authorization section must be completed in order to process your claim. **By signing and submitting this form you certify that the information provided in connection with this claim is complete, true and accurate.**

SECTION A – CLAIMANT INFORMATION

Claimant's Last Name	Claimant's First Name	Date of Birth MM | DD | YYYY	☐Male ☐Female

Canadian Address	City	Province	Postal Code

Email Address	Primary Phone Number	Secondary Phone Number

Country of Origin	Date of Arrival in Canada MM | DD | YYYY

For side-trips outside Canada only *Destination*:	*Departure Date* MM | DD | YYYY	*Return date* MM | DD | YYYY

SECTION B – CERTIFICATION & AUTHORIZATION – Signature required below

- This Authorization will permit Manulife and/or ACM to use the disclosed information for the purpose of determining my eligibility for coverage under my travel insurance policy and discuss any aspect of the adjudication of my claim with Manulife and its affiliates.
- I hereby authorize any doctor, hospital or facility providing medical or health-related services (any of which is a "Provider"), and any other insurer to release and exchange with Manulife and/or ACM or its representative, any information that is required to process this claim.
- I assign to Manulife any benefits payable from any other sources for losses covered under this policy, and I authorize and direct such payors to forward payment directly to Manulife and/or ACM.

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.

- For the purposes of discussing payments for medical services provided to me by any Provider, I also fully authorize Manulife and/or its Agent to release and disclose to any such Provider the contents and/or status of the adjudication of any claim for benefits under the Policy. In so doing, Manulife and/or its Agent may release and/or disclose my Medical Records and any adjudication decision, whether interim or final.
- In the event that the person receiving medical services is an unemancipated child, as defined by the laws of the province of my permanent residence, I hereby state that I am the parent/legal guardian of _____ (*insert name*) and that the authorization described above applies to his/her medical records.

A photocopy, facsimile, or electronic copy of this authorization shall be as valid as the original for the purpose of obtaining further information to process this claim.

I certify that the statements and particulars given herein together with those on any accompanying documents or telephone interviews relating to my claim are complete, true and correct to the best of my knowledge.

Manulife and ACM are committed to protecting the privacy, confidentiality and security of the personal information we collect, use and disclose. Your personal information will be used only for the purpose of providing you with the requested insurance services. For a copy of Manulife's Privacy policy, please visit: http://www.manulife.ca. For a copy of ACM's privacy policy, please refer to our website at www.active-care.ca.

Insured's Signature (If minor, signature of parent or legal guardian)	Date MM | DD | YYYY

If you authorize payment of this claim to anyone other than yourself or your provider, please provide name of recipient: (Last Name, First Name)

Payee address:	City	Province	Postal Code

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SECTION C – MEDICAL INFORMATION

Family Physician Name in Country of Origin	Phone	Fax
Physician Address		
Family Physician Name in Canada	Phone	Fax
Physician Address		

Injury

Brief Description of Injury and Diagnosis	Date of Injury MM | DD | YYYY

Illness

Date symptoms first appeared MM | DD | YYYY	First date of treatment MM | DD | YYYY	Diagnosis
Treating Doctor's Name	Phone	Fax
List names of any medications you were taking prior to visiting the Doctor:		
Have you ever experienced this illness or a similar problem before? ☐ No ☐ Yes		Date of Previous Occurrence MM | DD | YYYY
Is the illness related to your pregnancy? ☐ No ☐ Yes	Date Pregnancy Confirmed MM | DD | YYYY	Expected Date of Delivery MM | DD | YYYY
Do you have any chronic illness or disease? ☐ No ☐ Yes		Date Diagnosed MM | DD | YYYY
Describe Conditions / Diagnosis:		

SECTION D – OTHER INSURANCE COVERAGE

Do you have Canadian government health insurance? ☐ No ☐ Yes

Do you and/or your spouse have any other insurance coverage? ☐ No ☐ Yes – please specify:

☐ Credit Card ☐ Auto Insurance ☐ Employee/Group Benefit Plan ☐ Retiree Plan ☐ Other Travel Insurance

Name of Insurance Company	Policy Number	Is this coverage through your spouse? ☐ No ☐ Yes
Insurance Company's Address		Phone Number

Was the injury due to a Motor Vehicle Accident? ☐ No ☐ Yes – complete insurance information:

Name of Motor Vehicle Insurance Company	Policy #	Phone

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.

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SECTION E – EXPENSE SHEET

Please list below any PAID out of pocket expenses and include original or copies of the applicable receipts. Please save copies of all original claim forms, receipts and supporting documentation. ACM reserves the right to request original documentation when necessary to adjudicate your claim.

If you receive additional bills after submission of this expense sheet, contact our office for additional instructions prior to making a payment.

Facility Name (ex: doctor, pharmacy)	Description of Expense (ex: prescription)	Date of Service (MM/DD/YYYY)	Amount Paid ($ CAD)	Type of Proof of Payment Submitted (ex: receipt, credit card slip, bank statement, etc. If none, explain below)
		TOTAL		

If you have additional expenses or comments to support your claim, please note them below or submit additional pages.