# Local 183
# Members' Benefit Fund


**Policy No. BSC9020978**

Emergency Out of Province Medical

# Local 183
# Members' Benefit Fund

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*Claim Application Form*

## Emergency Out of Province Medical Coverage

**SUBMISSION INSTRUCTIONS:**

- Member to fully complete and sign the Emergency Out of Province Medical Coverage claim form;
- Include all receipts and invoices (originals required). Please keep a copy of completed application package for your records to substantiate your claim;
- Include copies of boarding passes & passport stamps indicating dates of travel;
- Policy No. BSC9020978;
- Send all original completed applications to:

**Local 183 Trust Administration**
1263 Wilson Avenue, Suite 205
Toronto, ON M3M 3G2

Tel: 416-240-7487
Toll Free Line: 1-888-790-3534

# LiUNA LOCAL 183 BENEFIT TRUST FUND
# TRAVEL MEDICAL INSURANCE CLAIM FORM

## 1 LiUNA LOCAL 183 BENEFIT TRUST FUND POLICY HOLDER INFORMATION

**NAME:** _____ **DATE:** _____

**ADDRESS:** _____ **HOME PHONE:** _____

_____ **MOBILE PHONE:** _____

**CITY:** _____ **PROV:** _____ **POSTAL:** _____ **EMAIL:** _____

**UNION ID:** _____

## 2 CLAIM INSTRUCTIONS

1. VERIFY THAT THE ABOVE INFORMATION IS ACCURATE AND MAKE CHANGES WHERE REQUIRED.
2. COMPLETE THIS FORM IN FULL AND ATTACH ALL DOCUMENTS AS REQUESTED.
3. SIGN AND DATE COMPLETED FORM AND RETURN PACKAGE TO:

**LiUNA LOCAL 183 BENEFIT TRUST FUND**
**SUITE 300, 901 KING STREET WEST**
**TORONTO, ON**
**M5V 3H5**
**CANADA**

FOR CLAIMS INQUIRIES PLEASE CONTACT: +1 647-258-7274 OR +1 877-490-7228.

**FAILURE TO COMPLETE THE CLAIM FORM AND ATTACH REQUESTED DOCUMENTS WILL DELAY THE PROCESSING OF YOUR CLAIM.**

**PLEASE ATTACH THE FOLLOWING DOCUMENTS:**

- SUBMIT PROOF OF RELATIONSHIP IF NAME DIFFERS FROM YOURS (E.G. MARRIAGE CERTIFICATE/COMMON LAW STATUS/FOR CHILDREN BIRTH CERTIFICATE NAMING PARENTS)
- ALL ORIGINAL MEDICAL BILLS AND PRESCRIPTION RECEIPTS
- DOCUMENTATION CONFIRMING YOUR DEPARTURE AND RETURN DATES (E.G. AIRLINE TICKETS, GAS RECEIPTS, ETC.)
- IN THE EVENT THAT YOU HAVE PAID ANY ELIGIBLE EXPENSES, PLEASE PROVIDE PROOF OF PAYMENT (E.G. CREDIT CARD VOUCHERS, CANCELLED CHEQUES, ETC.)
- A PHOTOCOPY OF THE SICK/INJURED PERSON'S PROVINCIAL HEALTH CARD

**PLEASE KEEP A COPY OF ALL THE SUBMITTED CORRESPONDENCE FOR YOUR RECORDS.**

## WHAT TO EXPECT DURING THE CLAIMS PROCESS

**IF YOU HAVE CONTACTED THE EMERGENCY ASSISTANCE CENTRE**, WE WILL HAVE ARRANGED TO HAVE ALL BILLS SENT DIRECTLY TO LiUNA LOCAL 183 BENEFIT TRUST FUND AND ONCE ELIGIBILITY AND PAYABILITY ARE DETERMINED, THE APPROVED PAYMENTS WILL BE SENT DIRECTLY TO THE FACILITIES AND/OR HEALTH PROVIDERS.

**IT IS OUR GOAL TO PROCESS ELIGIBLE CLAIMS IN A PROMPT MANNER**, HOWEVER PROCESSING MAY BE DELAYED FOR THE FOLLOWING REASONS:

- DELAY IN RECEIPT OF MAIL FROM PROVIDERS
- DELAY IN RECEIPT OF MEDICAL INFORMATION FROM YOUR TREATING OR FAMILY PHYSICIAN
- INCOMPLETE CLAIM FORM AND/OR INSUFFICIENT SUPPORTING DOCUMENTATION

**PLEASE NOTE:** DUE TO VARIATIONS IN HEALTH BILLING SYSTEMS BETWEEN COUNTRIES, YOU MAY RECEIVE INVOICES OR REMINDER NOTICES DIRECTLY FROM THE HEALTH PROVIDER. SHOULD YOU RECEIVE ANY SUCH CORRESPONDENCE **OR IF YOU HAVE PAID INVOICES DIRECTLY**, PLEASE FORWARD THESE TO THE ADDRESS INDICATED ABOVE.

**WE REQUEST THAT YOU SHOULD NOT PAY ANY MEDICAL ACCOUNTS DIRECTLY TO THE PROVIDERS UNLESS YOU HAVE BEEN ADVISED TO DO SO BY WORLD TRAVEL PROTECTION CANADA INC.**

**SHOULD YOU RECEIVE ANY PHONE CALLS REGARDING YOUR INVOICES.** PLEASE DIRECT THE CALLER TO +1 647-258-7274 OR +1 877-490-7228 AND WE WILL PROVIDE THE APPROPRIATE INFORMATION.

**IN ORDER TO EXPEDITE YOUR CLAIM, PLEASE RETURN THE COMPLETED CLAIM FORM AND ALL SUPPORTING DOCUMENTS AS SOON AS POSSIBLE AND RETAIN A COPY FOR YOUR RECORDS.**

## 3 INSURED DETAILS

| | | |
|---|---|---|
| YOUR POLICY NUMBER | | |
| NAME OF ILL OR INJURED PERSON | RELATIONSHIP TO INSURED | DATE OF BIRTH (DD/MM/YYYY) |
| PROVINCIAL HEALTH PLAN NUMBER OF CLAIMANT | VERSION CODE (IF APPLICABLE, PROVIDE THE LETTERS FOLLOWING THE NUMBER) | |
| DEPARTURE DATE (DD/MM/YYYY) | RETURN DATE (DD/MM/YYYY) | |

**COMPLETE REVERSE AND ATTACH ALL DOCUMENTS AS REQUESTED IN SECTION TWO**

# LiUNA LOCAL 183 BENEFIT TRUST FUND
# TRAVEL MEDICAL INSURANCE CLAIM FORM

## 4 CLAIM DETAILS

| NATURE OF SICKNESS OR INJURY | COUNTRY WHERE INCIDENT OCCURRED | DATE OF INCIDENT (DD/MM/YYYY) |
|---|---|---|
| DESCRIBE HOW INCIDENT OCCURRED | | |
| HAVE YOU PAID ANY INVOICES? ☐ YES ☐ NO | IF YES, PROVIDE AMOUNT PAID: $ | CURRENCY |

**NAME, ADDRESS AND TELEPHONE NUMBER OF ALL PHYSICIANS AND SPECIALISTS THAT THE CLAIMANT HAS SEEN PRIOR TO THE DEPARTURE DATE**

| NAME AND SPECIALTY | ADDRESS | TELEPHONE NUMBER |
|---|---|---|
| NAME AND SPECIALTY | ADDRESS | TELEPHONE NUMBER |
| NAME AND SPECIALTY | ADDRESS | TELEPHONE NUMBER |

## 5 OTHER INSURANCE COVERAGE (IF THE INSURED IS A CHILD, THIS SECTION IS APPLICABLE TO THE PARENT OR LEGAL GUARDIAN)

THIS INSURANCE PAYS ELIGIBLE EXPENSES IN EXCESS OF THOSE COVERED BY ANY OTHER INSURANCE. THEREFORE, IF AT THE TIME OF LOSS, YOU HAVE SIMILAR COVERAGE WITH ANOTHER PROVIDER (I.E. CREDIT CARD, TRAVEL INSURER, EMPLOYMENT GROUP HEALTH PLAN, PRIVATE OR PROVINCIAL AUTO PLAN, ETC.), WE WILL COORDINATE BENEFITS IN ACCORDANCE WITH THE CANADIAN LIFE AND HEALTH INSURANCE ASSOCIATION GUIDELINES.THIS SECTION MUST BE COMPLETED IN FULL. WITHOUT THIS INFORMATION WE WILL BE UNABLE TO PROCEED WITH YOUR CLAIM.

**PLEASE PROVIDE DETAILS (ATTACH ADDITIONAL INFORMATION IF NECESSARY)**

DO YOU AND/OR YOUR SPOUSE OR CHILD HAVE OTHER TRAVEL INSURANCE BENEFITS? (CHECK ALL THAT APPLY)

☐ EMPLOYER ☐ CREDIT CARD ☐ OTHER TRAVEL INSURANCE ☐ A RETIREE PLAN ☐ HOME, AUTO OR OTHER PLAN ☐ N/A

**1. EMPLOYER, RETIREE OR OTHER GROUP PLAN:**

NAME (INSURED, SPOUSE, CHILD): _____

INSURANCE COMPANY: _____ POLICY/PLAN #: _____ ID/CERTIFICATE #: _____

EMPLOYER GROUP: _____ EMPLOYER NAME: _____

EMPLOYER PHONE: _____

**2. CREDIT/BANK CARD:**

ISSUING BANK _____ CARD NO: _____

**3. INDIVIDUAL PLAN:**

NAME (INSURED, SPOUSE, CHILD): _____

INSURANCE COMPANY: _____ POLICY/PLAN #: _____ PHONE NUMBER: _____

**4. HOME, AUTO, OTHER PLANS:**

INSURANCE COMPANY: _____ POLICY/PLAN #: _____ PHONE NUMBER: _____

INSURANCE COMPANY: _____ POLICY/PLAN #: _____ PHONE NUMBER: _____

5. I HEREBY WARRANT THAT I DO NOT HAVE ANY OTHER TRAVEL OR OUT-OF-PROVINCE MEDICAL INSURANCE COVERAGE (CHECK IF APPLICABLE) ☐

## 6 CERTIFICATION AND AUTHORIZATION

**SPECIAL GHIP DIRECTION** **(IF THE CLAIMANT IS A CHILD, THIS SECTION APPLIES TO A PARENT)**

I DIRECT AND AUTHORIZE MY GOVERNMENT HEALTH INSURANCE PLAN (GHIP) TO MAKE PAYMENT IN RESPECT OF MY CLAIM FOR OUT-OF-COUNTRY HEALTH SERVICES TO **WORLD TRAVEL PROTECTION CANADA INC. (WTP)** DIRECTLY, AND I RELEASE GHIP, UPON PAYMENT TO WTP, FROM ANY FURTHER CLAIM OR CAUSE OF ACTION IN CONNECTION HEREWITH. I CONSENT TO THE DISCLOSURE BY GHIP TO WTP OF SUCH PERSONAL INFORMATION AS MAY BE NECESSARILY REQUIRED FOR PROCESSING OF MY CLAIM, INCLUDING DETAILS OF ANY DUPLICATE PAYMENT PREVIOUSLY MADE DIRECTLY TO ME.

I CONSENT AND AUTHORIZE GHIP TO DIRECTLY OR INDIRECTLY COLLECT INFORMATION CONTAINED IN THE CLAIM AND SOURCE DOCUMENTS PURSUANT TO SECTION 39(1) OF THE FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT, AND TO SECTION 4(2)(F) OF THE HEALTH INSURANCE ACT.

**PERSONAL INFORMATION NOTICE**

I UNDERSTAND THAT THE INFORMATION PROVIDED BY ME ON THIS CLAIM FORM AND OTHERWISE IN RESPECT OF MY CLAIM, IS REQUIRED BY AMERICAN HOME ASSURANCE COMPANY, ITS REINSURERS AND AUTHORIZED ADMINISTRATORS (THE "INSURER") TO ASSESS MY ENTITLEMENT TO BENEFITS, INCLUDING BUT NOT LIMITED TO DETERMINING IF COVERAGE IS IN EFFECT, INVESTIGATING THE APPLICABILITY OF EXCLUSIONS AND CO-ORDINATING COVERAGE WITH OTHER INSURERS. FOR THESE PURPOSES, THE INSURER WILL ALSO CONSULT ITS EXISTING INSURANCE FILES ABOUT ME, COLLECT ADDITIONAL INFORMATION ABOUT AND FROM ME, AND WHERE REQUIRED, COLLECT INFORMATION FROM AND EXCHANGE INFORMATION WITH THIRD PARTIES.

**CERTIFICATION**

THE STATEMENTS I PROVIDE IN COMPLETING THIS CLAIM FORM AND OTHERWISE IN RESPECT OF MY CLAIMS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. IN THE EVENT OF A FALSE OR MISLEADING STATEMENT IN THE MAKING OF THIS CLAIM, COVERAGE CAN BE CANCELLED, PAYMENT OF BENEFITS DENIED AND PAST CLAIMS PAYMENTS RECOVERED. I AGREE TO REFUND TO THE INSURER, THE AMOUNT OF ANY PAYMENTS MADE IN THE EVENT THAT SUCH AMOUNTS SHOULD NOT HAVE BEEN PAID IN RESPECT OF MY CLAIM.

**AUTHORIZATION**

I AUTHORIZE, FOR A PERIOD OF NOT LESS THAN TWELVE AND NOT MORE THAN TWENTY-FOUR MONTHS FROM THE DATE HEREOF, ANY PHYSICIAN, PRACTITIONER, HEALTH CARE PROVIDER, HOSPITAL, HEALTH CARE INSTITUTION, MEDICAL ORGANISATION, CLINIC AND ANY OTHER MEDICAL OR MEDICALLY RELATED FACILITY, ANY INSURANCE COMPANY OR REINSURANCE COMPANY, WORKERS COMPENSATION BOARD OR SIMILAR PLAN OR ORGANISATION, BENEFIT PLAN ADMINISTRATOR, FEDERAL, TERRITORIAL, OR PROVINCIAL GOVERNMENT DEPARTMENT, OR ANY OTHER CORPORATION OR ORGANISATION, INSTITUTION OR ASSOCIATION (INCLUDING OBTAINING INFORMATION FROM THE GROUP POLICYHOLDER OR MY EMPLOYER) TO RELEASE AND EXCHANGE WITH AMERICAN HOME ASSURANCE COMPANY, OR REPRESENTATIVES THEREOF, ALL PERSONAL HEALTH INFORMATION AND BENEFIT PAYMENT INFORMATION ABOUT ME OR ANY OTHER INFORMATION OR RECORDS ABOUT ME IN ITS POSSESSION THAT IS REQUESTED WHILE ADMINISTERING MY CLAIM.

I AGREE THAT A REPRODUCTION OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

SIGNATURE: _____ DATE: _____