1. Complete the Immigrants & Visitors to Canada Emergency Medical Claim Form in full, sign, and attach all requested documents. Email or mail the completed form along with applicable documents to the insurer's claims administrator:

   World Travel Protection
   901 King Street West, Suite 300
   Toronto, ON M5V 3H5

   email: travelclaims@wtp.ca

2. Additional supporting documents may be requested upon receipt and review of your Immigrants & Visitors to Canada Emergency Medical Claim Form.

3. Failure to complete this claim form in full and/or attach requested documentation will delay the processing of your claim.

4. If the claim reimbursement needs to be issued to anyone other than the policyholder, the Assignment of Payment Form must be completed and submitted with your claim form.

Note: *Claim form must be completed by a parent or legal guardian if the insured person is a minor.*

Please attach the following documents:

- All original medical bills and/or receipts; photocopies will not be accepted. Examples include:
  - Physicians' bill(s) and original receipt(s) of payment
  - Hospital bill(s) and original receipt(s) of payment
  - Prescription(s) and original receipt(s) of payment

- Attach any medical records you may have been given at the time of treatment. For hospitalization claims, a complete copy of your medical records from the treating facility is required.
  - This could include a copy of the emergency room report, discharge summary report or a written letter from your treating physician.

- **Important -** If you are providing documented testing, tests, test results, or investigations, exclude genetic tests. ***Genetic test** means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

- Proof of original departure from your home country if requested. Example:
  - Original or copies of airline tickets
  - Itinerary
  - Boarding passes
  - Original gas receipts
  - Original hotel receipts
  - Original meal receipts
  - Toll highway receipts
  - Original duty-free shop receipts
  - Copy of credit card statement showing purchases made in your Home Country before your trip

- Proof of payment, including original receipt, if you have paid for any eligible expenses

Please retain a copy of all submitted documents for your records.

The Assistance Centre must be contacted prior to treatment whenever possible. Failure to contact the Assistance Centre within 24 hours of receiving medical treatment or admission to hospital will limit benefits otherwise payable to 70% of eligible charges to a maximum of the sum insured.

G | m | S

IMMIGRANTS & VISITORS TO CANADA
Emergency Medical Claim Form

Clear Form

A. Policyholder Information

Policyholder's First Name	Policyholder's Last Name	Date of Birth *(DD/MM/YYYY)*
Contact Phone ( )	Email	Arrival Date in Canada *(DD/MM/YYYY)*
Visiting Address in Canada *(Number, Street, City, Province/State, Country, Postal Code/Zip Code)*		Immigrants & Visitors to Canada Policy Number

B. Patient Information

Is the patient information the same as the policyholder information in Section A? ❑ Yes ❑ No *If no, please provide the patient details below.*

Patient's First Name	Patient's Last Name	Date of Birth *(DD/MM/YYYY)*

C. Claim Details

Nature of Sickness or Injury *(diagnosis/symptoms)*	Date Incident Occurred *(DD/MM/YYYY)*

Please describe how the incident occurred:

Has the patient ever suffered symptoms, received medical advice, treatment, investigation and/or been prescribed medication for this medical condition prior to your departure from your Home Country? ❑ Yes ❑ No *If yes, please provide details below.*

Please specify the type of symptoms, medical advice, treatment, investigations and/or prescribed medication received for this medical condition.
The medical condition must have been stable, as defined in the policy wording, for 180 days prior to the effective date of the policy.

Summary of Expenses

Complete this section if you are submitting a claim for reimbursement. If additional space is required, please itemize bills on a blank piece of paper and attach to your claim form package.

Name of Service Provider *(Hospital, Physician, Clinic, etc.)*	Type of Expense *(Return of Vehicle, Emergency Room Visit, Prescription Drugs, etc.)*	Date of Service *(DD/MM/YYYY)*	Amount Paid	Currency

For complete coverage information, please refer to your policy wording.
Travel assistance and claims administration services are provided by World Travel Protection. Benefits are underwritten by Group Medical Services.
Group Medical Services is the operating name for GMS Insurance Inc. in provinces outside of Saskatchewan.

D. Other Insurance Coverage *(If the patient 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 (e.g. credit card, travel insurer, employment group health plan, private or provincial auto plan, etc.), benefits will be coordinated in accordance with the Canadian Life and Health Insurance Association guidelines.

Do you, your spouse, or your child have other travel insurance coverage? ❑ Yes ❑ No *If yes, please provide details below and attach additional information if necessary.*

Type of Plan *(e.g. credit card, group insurance, etc.)*	Policy Number/Credit Card Number

Name and Address of Institution or Insurance Company

❑ I hereby warrant that I do not have any other travel or medical insurance coverage *(check if applicable)*.

E. Local Medical History

Please provide the name, phone number and/or email address of all physicians or medical facilities where you received medical services while in your Home Country for the time period referenced below.

We will need records that include the 12-month period before you purchased the policy up to the date you arrived in Canada. **Example:** if you purchased your policy January 3, 2022 and arrived in Canada May 5, 2023. You must provide us with your local medical history from Jan 3, 2021 to May 5, 2023.

Physician Name/Medical Facility	Phone Number	Email

F. Assign a Benefit Payment to Another Person

If you want to assign someone other than you to receive the claim payment, please fill in the following information.

First Name	Last Name	Date of Birth *(DD/MM/YYYY)*

Address	City	Province	Postal Code

Phone ( )	Email

If assigning payment to your broker or agency, please fill in the following information.

Agency Name

Agency Address	City	Province	Postal Code

I /We direct and authorize any applicable Insurance Benefit Payment, subject to any policy terms and conditions, be made payable to the company or individual(s) as indicated above. I/We understand that this authorization overrides any other provisions for payment which may be set out in the policy wording.

I agree that this authorization directs Group Medical Services ("GMS") to pay any amount to which I may become entitled to my assignee. Once GMS has paid my assignee pursuant to this authorization I agree that I will not be entitled to demand payment for those amounts paid to my assignee from GMS.

Signature of Policyholder*(if a minor, signature of parent or legal guardian)*

X

G. Certification and Authorization

GMS, its administrator, World Travel Protection, and their agents, are obliged to collect and retain certain personal and/or health information about you in connection with your insurance coverage. They use and disclose that information only for the purposes of administering your policy/policies of insurance, providing customer service, and assessing and paying claims.

- I/We authorize any licensed physician, medical practitioner, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, and employer(s) to provide the Insurer, its administrator World Travel Protection, and their agents engaged to assist in the administration of this claim, any information, including personal information, data, or records that are in their possession/knowledge, regarding my medical history and treatment.
- I/We authorize GMS and its administrator, World Travel Protection, to coordinate the payment of benefits with any other insurance carriers which may also have a liability for this claim.
- I/We hereby irrevocably authorize the Insurer and its administrator, World Travel Protection to make any payments, receive payments and settle with any carriers on my behalf.

I hereby consent to the collection, use and disclosure by GMS its agents and administrators of the personal and health information about me disclosed herein and in all documents or information provided in connection with my policy/policies of insurance for the purposes cited above.

If the undersigned is signing on behalf of any person(s), the undersigned represents to having the authority to sign on behalf of such person(s) and confirms that each of the above declarations and authorizations are also provided on behalf of such person(s).

A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from date signed.

Signature of claimant *(if a minor, signature of parent or legal guardian)*	Patient Name *(please print full name)*	Date *(DD/MM/YYYY)*
X		

What to Expect During the Claims Process

It is our goal to process eligible claims in a prompt manner, however, processing may be delayed for the following reasons:

- Delay in the receipt of itemized medical accounts
- Delay in receipt of medical information from your treating or family physician
- Incomplete claim form and/or insufficient supporting documentation

In order to expedite your claim, please return the completed claim form and all supporting documents as soon as possible. Failure to complete the claim form and attach requested documents will delay the processing of your claim. Please keep a copy of all submitted correspondence for your records.