Insurance Travel Roadside Rewards

VISITORS TO CANADA CLAIM FORM

Policy No. _____
Case No. _____
Form No. SCOVTC102016E

HOW TO COMPLETE YOUR CLAIM FORM

Please complete all sections of the claim form. Failure to complete the claim form and attach the requested documents will delay the processing of your claim. Below you will find clarification for the sections of the claim form which are often missed or incomplete.

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 related to the claim. For the purposes of determining the validity of a claim under this policy, we may obtain and review the medical records of your regular physician(s) at home. Complete the Assignment of Benefits section if you wish to direct payment to a designated person.

SECTION D – OTHER INSURANCE COVERAGE

This section allows us to coordinate payments with any other insurance plans that you may have in addition to this policy such as an employer group benefit plan or coverage on your credit card.

REQUIRED DOCUMENTS

Submit the following documentation to support your claim (please do not staple documents):

- ❑ **Proof of payment including bills and itemized receipts**
  Credit/debit card transaction receipts or credit card/bank statements alone are insufficient. Official pharmacy receipts are required to claim for prescription drugs and must contain the patient's name, date of service, drug name and quantity dispensed.
- ❑ **All medical reports and clinical documentation provided at the time of treatment**
  These documents should include the diagnosis, list of medication given and type of treatment provided.
- ❑ **Proof of travel**
  Provide a copy of your stamped passport, travel itinerary or boarding passes confirming travel dates and entry into Canada.

SUBMITTING YOUR CLAIM

The completed & signed claim forms and applicable supporting documents can be sent to our office:

- ❑ **By Mail:** **Active Care Management**
  P.O. Box 308, Station A
  Windsor, ON N9A 6K7
- ❑ **By Email:** **OrionClaims@acmtravel.ca**

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

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Your travel insurance policy is underwritten by **Orion Travel Insurance Company** ("Orion"). Orion 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. Any mention of "CAA" in this document refers to CAA South Central Ontario.
IMPORTANT: The Authorization section must be completed in order to process your claim.
By signing this form you certify that the information provided in connection with this claim is complete, true and accurate.

SECTION A – CLAIMANT INFORMATION

Claimant Name	☐Male ☐Female	Date of Birth	MM	DD	YYYY
Canadian Address					
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:	Travel Dates:	MM	DD	YYYY	To:	MM	DD	YYYY

SECTION B – CERTIFICATION & AUTHORIZATION

- The insurer, its agents and administrators are obliged to collect and retain certain personal information 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 certify that the information I provided is true and correct to the best of my knowledge. I understand that this claim shall be void if, whether before or after the loss, I concealed or misrepresented any facts, or if any documents received regarding this claim have concealed or misrepresented any fact or circumstances concerning this claim.
- I authorize any licensed physician, medical practitioner, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, provincial health insurance plan and employer(s) to provide Orion Travel Insurance Company, and its representatives employed to assist in the administration of the claim, any information, including personal information, data or records that are in their possession/knowledge regarding my medical history and treatment.
- I hereby consent to the use by CAA, the Insurer, 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 of insurance for the purposes cited above. This consent is effective for one year from the date of the services provided and I may revoke this consent in writing at any time by advising CAA Travel Insurance.
- I Authorize Orion Travel Insurance Company, to coordinate the payment of benefits with any other insurance carriers which may also have a liability for this claim. I hereby irrevocably direct Orion Travel Insurance Company, to make any payments, receive payments and settle with other carriers on my behalf.
- Attention to Travel Service Providers: I hereby authorize and direct that you release to Orion Travel Insurance Company or its representative any and all information you have regarding my travels or use of your travel services for the purpose of determining my eligibility for coverage and or for benefits under my travel insurance policy.
- 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.

If claimant is a minor, print full name of parent or legal guardian, or if claimant is deceased, print full name of executor:

Signature	Date	MM	DD	YYYY

Assignment of Benefits Complete this section if you wish to direct payment to a designated person.

Payee	Phone Number
Payee address	

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SECTION C – MEDICAL INFORMATION

Claim Details

Name of Treating Physician or Medical Facility		Phone	Fax	
Description of illness or injury				
Date symptoms first appeared		MM	DD	YYYY
Date treatment first sought		MM	DD	YYYY
Have you ever experienced this sickness or a similar problem before? ☐ No ☐ Yes – When?		MM	DD	YYYY
If the condition was due to a pregnancy, what is the expected date of delivery?		MM	DD	YYYY

Your Medical History – Please list all your medical conditions (if additional lines are required, please attach separate page)

Medical condition	Date diagnosed	MM	DD	YYYY
Medical condition	Date diagnosed	MM	DD	YYYY
Medical condition	Date diagnosed	MM	DD	YYYY
List all medications routinely taken:				
Name of Family Physician in Country of Origin	Phone	Fax		
Name of Specialist in in Country of Origin	Phone	Fax		

SECTION D – OTHER INSURANCE COVERAGE

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

Do you or your spouse have any other insurance coverage for out-of-province travel such as an employer group benefit plan, retiree plan or coverage on your credit card? ☐ No ☐ Yes – please specify:

Name of Insurance Company	Policy Number	Certificate Number
If your credit card offers travel insurance, provide the name of the issuing bank		First 6 digits & last 4 digits of credit card

If you have credit card insurance, please provide the following information:

Name of Primary Insured / Cardholder	Date of Birth	MM	DD	YYYY
Signature of Primary Insured / Cardholder	Date	MM	DD	YYYY

Does this claim relate to a Motor Vehicle Accident? ☐ No ☐ Yes - provide the following information:

Motor Vehicle Insurance Company	Policy #	Phone

If you have claimed from any other insurer, please provide your claim number and attach a copy of the settlement.

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SECTION E – EXPENSE SHEET

List all PAID out of pocket expenses. Please save all original receipts and supporting documentation. ACM reserves the right to request original documents when necessary to adjudicate your claim.

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

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

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