Inpatriate/Expatriate Medical & Extended Health Claim Form

Please answer all questions fully – it helps us to provide better service.

All questions can be completed in ink (please print), however, the form must be signed and dated by ALL parties.
Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes.

Instructions to Insured:

1. Complete the Insured's Statement Section and the Extended Health Claim Section on Page 2.
2. Have your Physician complete the Attending Physician's Section if the claim is over $500.00.
3. Return the completed form to your Employer.
4. Please retain copies of receipts for your files, as originals will not be returned.

Instructions to Employer:

Complete the Employer Section and return the ORIGINAL signed form in its entirety along with ORIGINAL medical receipts to **AXA Assurances Inc.** at any of the following addresses: **Exchange Tower 130 King Street West 23rd floor, Suite 2350, PO BOX 160, Toronto Ontario, M5X 1C7**
2020 University Street, Suite 700, Montreal, Quebec H3A 2A5
220 - 12th Avenue S.W., suite 600, Calgary (Alberta) T2R 0E9

Insured's Statement Section

(to be completed in full by the Insured) **Policy Number:** _____

1. Insured's Full Name _____ Date of Birth D M Y
2. Dependent's Full Name (if applicable) | Relationship to Employee | Date of Birth D M Y

   _____ | _____ | D M Y

   _____ | _____ | D M Y

   (if space is insufficient, please use a separate sheet of paper)
3. Is the claim for a dependent child, age 21 or older? ☐ Yes ☐ No
4. Name and address of post-secondary school he/she is currently attending :

   _____
5. Complete Address in Canada _____
   Number & Street City Province Postal code
6. Complete Address outside Canada _____
7. Are you or your dependents eligible for benefits under a Provincial Health Plan? ☐ Yes ☐ No

   Any other medical plan? ☐ Yes ☐ No If "Yes", please complete the following :

   Name of eligible family member? _____ Relationship? _____

Name of Insurance Company administering the Plan _____

Assignment

(To be completed by the employee if cheque is to be made payable to the Provider.) This assignment is limited to physicians and hospitals for payment over $500.00.
I hereby assign to _____ benefits payable to me, but not to exceed the charge for the services described on this claim form. I understand that I am financially responsible for charges not covered by this assignment. I certify to the best of my knowledge that the statements made are true, correct and complete.

_____ D M Y _____ ( )
Signature of Insured Employee Date Telephone Number

Please return completed claim form with the "Consent to collect, use and disclose personal information" form.

Policy Holder's Statement Section

(to be completed by the Policy Holder)

1. Name of Employee _____ Division/Class (if applicable) _____
2. Effective Date of Employee's Coverage D M Y
   3. Effective Date of Dependent's Coverage D M Y
   4. Termination Date of Coverage D M Y
5. Is claim being filed for Worker's Compensation Benefits/WSIB? ☐ Yes ☐ No If "Yes", claim number _____
6. Employer's Name _____ Telephone No. ( )
7. Address _____
   Number & Street City Province Postal code

_____ _____ _____
Authorized Signature Print Name Official Position/Title

Attending Physician's Section

(to be completed by the Attending Physician) **Policy Number:** _____

1. Diagnosis (describe complications, if any) and Procedures

2. When did the patient first consult you for this condition? D M Y

3. To the best of your knowledge, when did the symptoms first appear or accident happen? D M Y

4. Has the patient ever had same or similar condition? ☐ Yes ☐ No

   If "Yes", state particulars

5. Describe any other disease or infirmity affecting the patient's present condition :

6. Is the condition due to pregnancy? ☐ Yes ☐ No

7. If "Yes", what was the approximate date of commencement of pregnancy? D M Y

8. Was the patient hospitalized? ☐ Yes ☐ No If "Yes", From D M Y To D M Y

9. Name and address of hospital

10. If an operation was performed, state the nature of the operation

11. Date Performed D M Y 12. By Doctor

13. Physician's Name (please print) Telephone No. ( )

    Address
    Number & Street City Province Postal Code

    Date D M Y Physician's Signature _____

The patient is responsible for securing the Attending Physician's Statement and for any charges made for its completion.

Extended Health Claim Section

(to be completed by the Employee)

Instructions: All claims must be accompanied by the original receipts, itemized statements or invoices; treatment and diagnosis must be included. Photocopies will not be accepted. If space is insufficient, please use a separate sheet of paper.

Important: Please complete the form in full to avoid delay in processing your claim.

First Name of Claimant	Nature of Illness/Injury	Drug name and strength of each prescription (if not for drugs, state the nature of the expense)	Date of Receipt (D-M-Y)	Cost of each item	Country and Currency	**For Office Use Only** Currency Rate	Canadian Funds

AUTHORIZATION AND RELEASE

I, the undersigned, _____ irrevocably direct and authorize GHIP to make payment in respect to my claim for out-of-country health services to AXA Assurances Inc. directly and I hereby release GHIP, upon payment to AXA Assurances Inc. from any further claim or cause of action in connection therewith.

I hereby 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 Information and Protection of Privacy Act, and Section 4(2) of the Health Insurance Act.

I consent to the disclosure by GHIP to AXA Assurances Inc. of such personal information as may be necessarily required for the processing of my claim for out-of-country health services, including the details of any duplicate payment previously made directly to me.

Date: _____

_____
(Signature of/on Behalf of Insured)

_____
(Relationship if other than claimant)

INFORMATION ON CLAIMANT
Name:
Home Province & Address in Canada:
Date of Birth:
Health Insurance #:

TO BE COMPLETED BY AXA ASSURANCES INC.
Name of Insured Employee:
Policy #: