AIG Insurance Company Of Canada
120 Bremner Boulevard, Suite 2200
Toronto, ON M5J 0A8
416-596-4005 | 1-877-317-8060
www.aig.com

OUT-OF-COUNTRY/PROVINCE CLAIM FORM

INSTRUCTIONS: Please complete, sign and attach all original receipts and proof of travel to AIG promptly. An incomplete claim form without the required documents will result in a delay of processing your claim. Kindly retain a copy for your records.

POLICY NO:_____ **Policy Holder:**_____ CERTIFICATE#: (if applicable) _____

SECTION A PATIENT INFORMATION

Last Name: First Name:

Patient's Name: Relationship to Member:

Patient's Date of Birth: MM/DD/YYYY ☐ Male ☐ Female E-mail:

Address: Apt.#:

City: Province: Postal Code:

Home Phone #: Other Phone#: Email:

Patient's Health Card No:
and Verification Code:

Total Amount being claimed: $ Currency:

Have you paid for the expenses? ☐ YES ☐ NO Amount Paid $:

SECTION B TRAVEL DETAILS (Provide Proof of Travel)

Departure Date: MM/DD/YYYY Return Date: MM/DD/YYYY Mode of Travel: ☐ Car ☐ Airplane Other:

Destination: Reason for Travel: ☐ Business ☐ Vacation ☐ Study ☐ Medical Care Other:

Temporary Address: Please provide the full mailing address

SECTION C OTHER INSURANCE INFORMATION

Employer Name: ☐ Retired Employer Phone#:

Employer Address:

Do you have any other Insurance Coverage? (check all that apply- include required information)

☐ Spouse ☐ Travel ☐ Hospital/ Medical ☐ Home/Auto ☐ Other ☐ I have no other insurance

1. Name of Insurance Company:

Address: Phone # :

Policy No.: Certificate/ ID #:

2. Name of Insurance Company:

Address: Phone # :

Policy No.: Certificate/ ID #:

Do you have a credit card which provides out-of- province medical coverage? ☐ YES ☐ NO

If Yes: Name of Credit Card Company:

Address: Phone #:

Policy No.: Certificate/ ID #: Card #: Expiry Date.:

Did you submit a claim with any other company? ☐ YES ☐ NO

SECTION D MEDICAL INFORMATION/ CLAIM DETAILS

Date of initial onset of illness or injury: MM/DD/YYYY Diagnosis:

Details of occurrence:

Was medical treatment required as a result of an accident? ☐ YES ☐ NO Location of accident:

Details of accident (if automobile accident include insurance information):

Was medical treatment required due to an emergency? ☐ YES ☐ NO

Were you advised to seek treatment for this condition in a place other than your normal province of residence? ☐ YES ☐ No

If yes, please explain:

Were you hospitalized? ☐ YES ☐ NO If yes, advise date of admission: MM/DD/YYYY date of discharge: MM/DD/YYYY

Name of Hospital: Phone #:

Address of Hospital:

Have you had any of these conditions before? ☐ YES ☐ NO If yes, indicate the date you were **last** treated: MM/DD/YYYY

Name of Family Physician: Phone # :

Address:

Name of first Physician consulted: Phone # :

Address:

SECTION E AUTHORIZATION AND RELEASE

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 AIG Insurance Company of Canada, 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-coordinating 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.

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 organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with AIG Insurance Company of Canada, 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

Claimant or Legal Guardian's Signature: Date:

SECTION F PROVINCIAL GOVERNMENT HEALTH INSURANCE AUTHORIZATION AND RELEASE
Ontario Residence ONLY

1. Direction and Release

I _____ irrevocably direct and authorize the Ontario Ministry of Health and Long-Term Care ("the Ministry") to make payment in respect of my claim for out-of-country health services to AIG Insurance Company of Canada directly and I hereby release OHIP, upon payment to AIG Insurance Company of Canada from any further claim or cause of action in connection therewith.

2. Consent

I authorize the Ministry to collect my personal health information, consisting of:

- information relating to my receipt of health care services outside of Canada, and
- information relevant to the reimbursement of those services under the Health Insurance Act, R.S.O. 1990, c. H.6

from AIG Insurance Company of Canada, and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying my request for payment under the Health Insurance Act, including the details of any duplicate payment previously made to me, to AIG Insurance Company of Canada.
I understand the purpose for the Ministry's collection and disclosure of this personal health information.
I understand that I can refuse to sign this consent form.

If providing consent on behalf of a person who is not capable of consenting to the collection, use and disclosure of personal health information:

I _____ am the substitute decision-maker for _____ (name of Insured Person for whom you are the substitute decision-maker). I authorize the Ministry to collect personal health information about the Insured Person, consisting of:

- information relating to the Insured Person's receipt of health care services outside of Canada, and
- the reimbursement of those services under the Health Insurance Act, R.S.O.1990, c. H.6.

from AIG Insurance Company of Canada, and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying my request for payment under the Health Insurance Act, including the details of any duplicate payment previously made to me, to AIG Insurance Company of Canada.
I understand the purpose for the Ministry's collection and disclosure of this personal health information.
I understand that I can refuse to sign this consent form.

3. Authorization

My Name:	Address
Home Tel:	Work Tel:
Signature:	Date:
Witness Name:	Address:
Home Tel:	Work Tel :
Signature:	Date:

PLEASE REMEMBER TO ATTACH ALL ORIGINAL RECEIPTS AND PROOF OF TRAVEL.
MAIL TO:

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Toronto, ON M5J 0A8