Claims Administration
OLD REPUBLIC INSURANCE COMPANY OF CANADA
Box 557, 100 King Street West
Hamilton, Ontario L8N 3K9
Toll Free: 888.831.2222
Fax: 866.551.1704

VISITORS TO CANADA Insurance Claim Form

PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF THE OCCURRENCE

Part I — INSURED'S INFORMATION

Name of Primary Insured *(Last, First)*	Policy No.	Date of Birth

Full Address

Part II — PATIENT'S INFORMATION

Patient's Name *(Last, First)*	Relationship to Insured	Date of Birth

Part III — EXPLANATION OF LOSS

Describe fully the circumstances of the sickness or injury

Date of onset of sickness or injury *(MM / DD / YY)*	Date of first consultation *(MM / DD / YY)*	Name of Physician who treated you	
Full address of Physician		Were you hospitalized? ❑ Yes ❑ No	If yes, name of hospital
Full address of Hospital		Admission date *(MM / DD / YY)*	Discharge date *(MM / DD / YY)*
Do you have any chronic condition or Infirmity? ❑ Yes ❑ No	If yes, Describe?	Have you ever had the same or similar condition? ❑ Yes ❑ No	If yes, Describe?

Part IV — OTHER COVERAGE

Do you have any other Health Insurance coverage/plans?
❑ Yes ❑ No

IF YES, PLEASE COMPLETE:

1) Name of Insurance Company	Policy No.	Telephone No.

Address of Insurance Company

2) Name of Insurance Company	Policy No.	Telephone No.

Address of Insurance Company

I DECLARE THAT THE ABOVE INFORMATION IS TRUE, COMPLETE AND CORRECT.

I/We authorize any other insurance plan, under which I/We have coverage, to disclose information as may be necessary or to make payment in respect of my/our claim to Old Republic Insurance Company of Canada directly. I/We also authorize Old Republic Insurance Company of Canada to disclose to any other Plan, under which I/We have coverage, any and all information as may be necessary with respect to my/our claim.

_____ _____
Signature of Insured/Claimant Date *(MM / DD / YY)*

_____ _____
Signature of Insured/Claimant Date *(MM / DD / YY)*

Part V	**MEDICAL EXPENSES**					
Name of Medical Service Provider/Doctor	Date of Service *(MM / DD / YY)*	Amount on Invoice *(IN CDN $)*	Did you pay this invoice?	Name of other Health Insurance Company/Plan Invoice submitted to	Amount paid by other Insurance Company/Plan	Amount claimed *(IN CDN $)*
					Total Amount Claimed in CDN $	

If you have more expenses, please provide a breakdown below using the above format.

IMPORTANT – **CLAIM CANNOT BE PROCESSED IF THIS FORM IS INCOMPLETE. PLEASE COMPLETE ALL APPLICABLE AREAS.**

Part VI PATIENT CONSENT TO DISCLOSE HEALTH INFORMATION

Patient's full name at time of treatment: _____

Date of birth: (MM/DD/YY) _____ | _____ | _____

Address: _____

Purpose of release: **ADJUDICATION OF TRAVEL INSURANCE CLAIM**

Effective Date of Insurance Coverage: (MM/DD/YY) _____ | _____ | _____

Medical Facilities: (List all doctors consulted for this condition and hospitals where confined)

Name	*Address*	*Telephone No.*	*Fax No.*	*Dates*
_____	_____	_____	_____	_____ | _____ | _____
_____	_____	_____	_____	_____ | _____ | _____
_____	_____	_____	_____	_____ | _____ | _____

You are authorized to give **Old Republic Insurance Company of Canada** and its affiliates, reinsurers, agents, consumer reporting agency, or independent claims administrator acting on behalf of Old Republic Insurance Company of Canada, any information concerning insurance coverage, medical care, advice, treatment or supplies, or any other information that may have bearing on the request for benefits submitted in conjunction with the travel insurance policy.

Information to be released:

All medical records of the Patient for up to 180 days before the Effective Date of Insurance Coverage as shown above through the date of this consent as shown below as applicable based on the patients age as outlined the policy. "Medical records" includes, without limitation, diagnosis list, medication list, physician dictation, office notes, physical therapy records, occupational therapy records, pathology reports, cytology reports and the results of all laboratory tests.

Send to: **Travel Claims Department**
P.O. Box 557, 100 King St. W.
Hamilton, ON L8N 3K9
Telephone: 1-888-831-2222 Fax: (905) 528-8338

By signing below, I understand that:

1. The information in my health record may include information relating to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I have the right to revoke this consent at any time by providing my written revocation to the facility where my records are kept.
3. A revocation will not apply to information that has already been released in response to this consent.
4. A revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. Unless otherwise revoked, this consent will expire in six months.
6. Consenting to the disclosure of this health information is voluntary. I can refuse to sign this consent.
7. Any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I authorize Old Republic Insurance Company of Canada to disclose my health or claim information to any relevant source (e.g. airline, tour operator, travel suppliers, etc.) for the purpose of obtaining recoveries or any outstanding refunds after my insurance claim has been settled. I hereby assign to Old Republic Insurance Company of Canada any benefits or recoveries obtained from these sources for losses covered under this policy. I direct these sources to forward reimbursement to Old Republic Insurance Company of Canada with regard to these losses.

Signature of patient or authorized person: _____ Date: (MM/DD/YY) _____ | _____ | _____

Relationship/Reason patient is unable to sign: _____

PLEASE SIGN THE ABOVE AUTHORIZATION AND HAVE YOUR DOCTOR COMPLETE THE ATTENDING PHYSICIANS STATEMENT.

Part VII TO BE COMPLETED BY THE PHYSICIAN

Patient's Name _____

Address _____

1. Diagnosis - Nature of Injury or Sickness causing Cancellation/Interruption *(Please Be Specific)*

   a) Primary Diagnosis _____

   b) Secondary Diagnosis _____

2. a) When did symptoms first appear or injury occur? *(MM/DD/YY)* _____ I _____ I _____

   b) When did Patient first consult you? *(MM/DD/YY)* _____ I _____ I _____

   c) If Patient was referred **from** another physician, name of other physician. Tel No. (_____) _____

   _____

   d) If Patient was referred **to** another physician, name of other physician. _____ Tel No. (_____) _____

   _____

3. Dates of all medical visits as it relates to the condition:

	Date of Consultation (MM/DD/YY)	*Describe the Condition/Treatment*	*Medication Prescribed/Changed*
a)	_____ I _____ I _____	_____	_____
b)	_____ I _____ I _____	_____	_____
c)	_____ I _____ I _____	_____	_____

4. a) Has the Patient been hospitalized for this condition or related condition(s)? ❑ Yes ❑ No

   b) If Yes, date of admittance: *(MM/DD/YY)*_____ I _____ I _____ Date of discharge: *(MM/DD/YY)* _____ I _____ I _____

   c) If Yes, Describe: _____

5. If condition was related to pregnancy, when was the pregnancy first diagnosed? *(MM/DD/YY)* _____ I _____ I _____

   Expected Delivery Date? *(MM/DD/YY)* _____ I _____ I _____

Physician's Remarks: _____

_____

_____

_____

_____

_____

Signature of Physician _____ Date Completed: _____ I _____ I _____

Name of Physician: _____ Telephone No. (_____) _____

Address of Physician: _____ Fax No. (_____) _____

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OLD REPUBLIC CANADA
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Assignment of Benefits (Optional)

If you would like any eligible payments to be issued to someone other than yourself, kindly complete the following:

Re: Travel Insurance Policy No. _____

I _____ hereby assign, transfer and request that payment for

this claim be made directly to_____.

I acknowledge and accept that all claims, and rights to the travel insurance benefits which may become payable under the terms and conditions set forth and described in the Travel Insurance Policy as a result of this claim are payable as noted above.

Name of Insured: _____

Signature of Insured: _____

Date: _____

Please indicate full address of where payment should be sent:

_____
_____
_____
_____