JF Canadian Travel Insurance
Medical Claim Form

Ontime Care Worldwide Inc.
P.O.Box 82029, 420 Hwy 7 E,
Richmond Hill, ON, L4B 3K2, Canada
Toll free Canada/US 1-888-988-3268
Collect Worldwide 905-707-9555

INSTRUCTION

- In the event of hospitalization, Ontime Care Worldwide Inc. ("OTC") must be notified prior to, or within, 24 hours of admission to hospital. OTC is to approve in advance all major tests, procedures or treatments.
- It is your responsibility to ensure that OTC is notified in advance of any surgery or invasive investigations. Do not assume that someone will contact OTC on your behalf.
- All claims must be reported to OTC within 30 days of occurrence. Written proof of claim must be submitted to OTC within 90 days of occurrence.
- You are responsible for all fees charged for completion of this form and any supporting documentation.

Claims Submission

To complete the claim submission, patients must obtain and submit to OTC a copy of the emergency room report and all hospital records if treated at a hospital. For patients treated at a medical clinic, medical centre or by a family physician, a physician's medical report is required for claim submission

If you have paid for services, you must submit all original itemized invoices and payment receipts from the medical service provider or hospital detailing treatment and treatment dates. Photocopies of receipts will not be accepted.

Proof of departure for multi-trip/annual plans: copy of stamp on the passport, boarding pass, flight ticket. If driving, financial statement showing purchases before leaving province and after arriving at destination.

Complete all sections below and ensure this form is signed before submitting to OTC with all original invoices, physician and medical reports and original prescription pharmacy receipts. Failure to complete the form or submit supporting documentation will delay processing

Please use **Canada Post** to send the claim file and be sure to keep a copy of your claim for your records.

SECTION A: CLAIMANT

Insured's First Name:_____ Last Name: _____

☐ Male ☐ Female Date of Birth (MM/DD/YY):_____ Policy #: _____

Address in Canada

Street Address:_____

City/Town:_____ Province:_____ Postal Code:_____

Telephone:_____ Email address:_____

Date of Departure:_____ Date of Return to home province:_____

Destination:_____

Name and Address of Family Physician in Home Province

Name:_____

Address:_____

City:_____ Province:_____ Postal Code:_____

Do you have other travel medical insurance coverage? ☐ Yes ☐ No If 'Yes', please provide the following information:

Name of Insurance Company:_____

Policy #:_____ Member ID:_____ Telephone:_____

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Do you have insurance coverage through your spouse? ☐ Yes ☐ No If 'Yes', please provide the following information:

Name of Insurance Company:

Policy #:_____ Member ID:_____ Telephone:_____

Spouse's Name:_____ Spouse's Date of Birth:_____

Do you have credit card insurance coverage? ☐ Yes ☐ No If 'Yes', please provide the following information:

Name of the financial Institution:_____

First 6 digits of credit card: _____ Expiry Date(MM/YYYY): _____

Name of Cardholder(Please print):_____ Cardholder Signature: _____

Do you have insurance benefits available through group insurance or any other source?

☐ Yes ☐ No If 'Yes', provide details below.

Group Insurance

Name and Address of Insurance Company:_____

Policy Number:_____ Telphone#:_____

Other Travel Insurance

Name and Address of Insurance Company:_____

Policy Number:_____ Telphone#:_____

SECTION B: MEDICAL INFORMATION

Brief description of your sickness or injury:_____

_____

_____

Date your symptoms first appeared or injury occurred (MM/DD/YY):_____

Date you first saw a physician for this condition (MM/DD/YY):_____

Have you ever been treated for this or a similar condition before? ☐ Yes ☐ No

If you answered "yes", provide all dates of treatment and list all medications taken before the effective date of the current policy:

Date (MM/DD/YY):_____ Medication:_____

Date (MM/DD/YY):_____ Medication:_____

Date (MM/DD/YY):_____ Medication:_____

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SECTION C: EXPENSES CLAIMED

Name of Provider	Diagnosis	Date of Service (MM/DD/YY)	Amount Billed ($)	Amount Paid ($)

SECTION D: AUTHORIZATION AND CERTIFICATION

Berkley and OTC are committed to protecting the privacy, confidentiality and security of the personal information we collect, use, retain and disclose. Your personal information will be used only for the purposes of providing you with the requested insurance services. Please contact us if you want to read a complete copy of Berkley or OTC's privacy policy.

I authorize any doctor, hospital or facility providing medical or health-related services, third-party administrator, and any other insurer to release and exchange with Berkley, OTC, or its representatives, any information that is required to process this claim. I assign to Berkley and OTC any benefits payable from any other sources for losses covered under this policy, and I authorize and direct such payors to forward payment directly to Berkley and OTC. I also authorize any third party providing me with assistance in this claims process to have access to any and all relevant claims information related to the adjudication of my claim with Berkley and OTC. I confirm that I am authorized to act on behalf of my dependents for these purposes. A photocopy of this authorization shall be as valid as the original.

I certify that the information provided in connection with this claim is complete, true and accurate.

Full Name of Insured (please print): _____ Date: _____

I authorize payment of this claim to (print name): _____

Insured's Signature (if minor, signature of parent or legal guardian): _____

Signature of policyholder of other insurance specified in Section A (if applicable): _____

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