CANUCK VOYAGE

CLAIM FORM

INSTRUCTIONS

IMPORTANT

- Claims must be reported to Intrepid 24/7™ within 30 days of occurrence, with written proof submitted within 90 days of occurrence.
- Complete all sections and ensure this form is signed before submitting to Intrepid 24/7™ with all original invoices, physician and medical reports, and original prescription pharmacy receipts. Patients must obtain all medical records from the treatment facility, including emergency room reports, hospital or medical clinic reports, and any physician or treatment records.
- Failure to complete and sign this form in its entirety, or to submit supporting documentation, will delay processing of your claim.
- You are responsible for all fees charged for completion of this form and any supporting documentation.
- 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.

SECTION A: CLAIMANT

YOU MUST INCLUDE THE FOLLOWING WITH THIS COMPLETED FORM:

1) A copy (front and back) of your government issued health insurance card.

2) You must also provide proof of the actual departure date from your province or territory of residence. Proof includes, but is not limited to, a flight itinerary, gas receipts or toll-road receipts.

3) Proof of re-entry back into Canada. Proof includes but is not limited to: a flight itinerary, gas or purchase receipts upon re-entry to Canada.

If you are submitting your claim electronically, please retain the original receipts/invoices as they may be requested at a later date.

CLAIMANT

Claimant's First Name | Claimant's Last Name | Policy Number

Date of Birth (MM/DD/YYYY) ☐ Male ☐ Female ☐ Non-binary ☐ Undisclosed

Departure Date from Canada (MM/DD/YY) | Scheduled Return Date to Canada (MM/DD/YY)

CLAIMANT'S MAILING ADDRESS OUTSIDE CANADA

Unit # | Street Address

City | State/Province | Country | ZIP/Postal Code

Phone | Email

CLAIMANT'S MAILING ADDRESS IN CANADA

Unit # | Street Address

City | Province | Postal Code

Phone | Email

TREATING PHYSICIAN FOR THIS CLAIM

Full Name | Clinic Name or Practice

Unit # | Street Address

City | State/Province | Country | ZIP/Postal Code

Phone | Fax

CLAIMANT'S FAMILY DOCTOR IN CANADA (IF APPLICABLE)

Full Name | Clinic Name or Practice

Unit # | Street Address

City | Province | Postal Code

Phone | Fax

SECTION B: OTHER INSURANCE COVERAGE

Is the claimant covered by another medical or travel insurance policy (including coverage through a spouse, parent, or guardian)? ☐ Yes ☐ No

IF YES, provide details of other insurance coverage below.

Full Name of Policyholder	Insurance Company			
Policy/Plan Number	ID/Certificate Number	Employer Group Number (if applicable)	Employer Name (if applicable)	Employer Phone (if applicable)

SECTION C: CLAIM INFORMATION

Description of claimant's sickness or injury (if this space proves insufficient, additional information can be attached):

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

Has the claimant previously been treated for this, or a similar or related, condition? ☐ Yes ☐ No

IF YES:

Date the claimant first saw a physician for this, or a similar or related, condition (MM/DD/YY):

Provide all dates of treatment and list all medications taken for this, or a similar or related, condition before the effective date of the current policy:

Treatment Date (MM/DD/YY)	Medication

SECTION D: EXPENSES CLAIMED

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

SECTION E: AUTHORIZATION AND CERTIFICATION

Certain Lloyd's Underwriters ("Lloyd's"), Intrepid 24/7™ ("Intrepid"), its agents, and administrators, are obliged to collect and retain certain personal and/or health information about you in connection with your insurance coverage. We use and disclose this information only for the purposes of administering your policy/policies of insurance, providing customer service, and in assessing and paying claims. We 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. Lloyd's and Intrepid's complete privacy policies are available upon request.

I authorize any doctor, medical practitioner, hospital, facility providing medical or health-related services, third-party administrator, provincial plan and any other insurer to release and exchange with Lloyd's, Intrepid, or its representatives, any information (including personal health data and records) required to process this claim. I authorize any third party providing me with assistance in this claim process to have access to any and all relevant claims information related to the adjudication of my claim with Lloyd's and Intrepid. I authorize Intrepid to coordinate the payment of benefits with any insurance carriers that may have a liability for this claim and assign to Lloyd's and Intrepid any benefits payable from any other sources for losses covered under this policy, and authorize and direct such payers to forward payment directly to Lloyd's and Intrepid. I confirm below by my signature that I am authorized to act on behalf of any of my dependants 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): _____

If applicable, I authorize payment of this claim to (please print): _____

_____

Signature of insured (if insured is a minor, signature of parent or legal guardian)

_____

Signature of policyholder of other insurance in Section B (if applicable)

Date (MM/DD/YY): _____

IN THE EVENT OF AN EMERGENCY PLEASE CONTACT INTREPID 24/7™ IMMEDIATELY AT:

1-800-203-8508
toll-free from Canada and the USA
e-mail: **intrepid@intrepid247.com**

+1-416-646-3107
collect where available

CLAIMS SUBMISSION:

Intrepid 24/7
150 King St West, Suite 602 - PO Box 75
Toronto, ON M5H 1J9 Canada

e-mail: **claims@intrepid247.com**
fax: 1-416-730-1878