Let's get started! We're looking forward to helping you with your claim.

Below is the list of required documents and additional information to finalize your claim.
Be sure to review each item carefully and complete it as accurately as possible.

It's best to submit your claim forms to us within 60 days from the date the claim was opened—the sooner we receive your completed claim form, the faster we can start processing your claim.

Here's what we'll need:

- **Visitor to Canada Medical claim form**
  - Be sure to answer all the questions, completing both sides of the form.
  - Sign the Medical Authority on the back.

- **All original, itemized bills and receipts**

- **All original prescription drug receipts**
  - Be sure they are the official tax receipts and not credit card or till receipts.

- **Proof of payment**
  - If you have already paid the medical provider or facility directly, provide proof of the amount paid so we can process your reimbursement.
  - This could be a receipt marked "paid" from the provider, a credit card statement, or a copy of a cancelled cheque.
  - If you paid by credit card, you may want to include a copy of the credit card statement showing the exchange rate and amount charged in Canadian dollars.

- **Written description (if your claim is related to an illness)**
  - Describe the diagnosis, symptoms, or the nature of the illness you are claiming for.

- **Written description (if your claim is related to an injury)**
  - Describe the injury and tell us how it happened.
  - Be sure to include the date and time of the incident as well as the name, phone number and email address (if possible) of the person or company you feel is responsible.

(If you need more space than what is provided on the claim form, feel free to write this information on a separate piece of paper—any format is fine.)

In the unfortunate event that you are filing a claim for someone who has passed away, please also submit:

- A copy of the Insured's Death Certificate.
- A copy of the section of the Will indicating who is legally authorized to act on behalf of the Estate.
- If these expenses were incurred while the Insured was travelling, the original receipts for cremation or for homeward carriage for burial.

If you have any questions, feel free to call us toll free at 1-800-663-0399 or collect at 604-278-4108. You can also email us at claims@tugo.com.

We look forward to completing your claim as quickly as possible.

Take care,

Claims at TuGo

Visitor to Canada Medical Claim

Claims at TuGo, 10th Floor, 6081 No.3 Road
Richmond, BC Canada V6Y 2B2
Tel: 604-278-4108 **Fax:** 604-276-4593
Canada & USA Toll Free: 1-800-663-0399

Claim No.

For office use only

(Please print clearly. This form will be returned if not completed in full.)

Name of the Insured claiming FIRST NAME LAST NAME ○ M ○ F

Address _____

City _____ Prov. _____ Postal code _____

Telephone ( ) _____ E-mail _____

Date of birth MM | DD | YYYY Country of residence _____

Arrival date in Canada MM | DD | YYYY Planned departure date from Canada MM | DD | YYYY

What is the purpose of your visit to Canada? ○ Temporary visit ○ Returning Canadian ○ Immigrating ○ Permanent Resident

Travel insurance policy no. _____ Effective date MM | DD | YYYY

Begin with the first medical treatment in Canada (or U.S. and Mexico if applicable) and specify the Sickness(es) or Injury treated/medical diagnosis, date of treatment, physician's name, cost of treatment and drugs prescribed.

Date of Treatment	Sickness/Injury & Service Provided	Attending Physician's Name	Cost of Treatment	Drugs Prescribed
(eg.) Jan 1 2015	Rash on arm—consultation	Dr. Jones	$55	Fucidin

1. Please provide a brief description of how, when and where the sickness or injury occured _____

2. If hospitalized overnight: Name of hospital _____ Prov. _____
   Date of admission MM | DD | YYYY Date of discharge MM | DD | YYYY

3. Have you been treated for the listed sickness(es) before? ○ Yes ○ No
   If "Yes", please provide the date(s) and place(s) of previous treatment _____

4. Please provide the name, address and phone number of your most recent physician before your arrival in Canada.

5. Were you taking any prescribed drugs or medications prior to the effective date of your policy? ○ Yes ○ No
   If "Yes", please list the names of these drugs or medications _____

6. Are you covered under any other medical insurance plan, either private or provincial/government? ○ Yes ○ No
   If "Yes", please provide:
   Name of plan _____ Plan, policy or contract no. _____ Effective date MM | DD | YYYY

7. If you prefer that reimbursement be made payable to someone other than yourself, please print their name below, and provide your signature as authorization.

Name of payee _____ Relationship to Insured _____

Signature of Insured **X** _____ Date MM | DD | YYYY

PLEASE COMPLETE AND SIGN REVERSE SIDE

FAILURE TO PROVIDE ALL INFORMATION REQUESTED IN THIS FORM AND SIGNED MEDICAL AUTHORITY MAY CAUSE EXTREME DELAYS IN PROCESSING YOUR CLAIM.

Please ensure that this completed form is returned promptly to **Claims at** TuGo with signed Medical Authority.

MEDICAL AUTHORITY

Authorization to physicians, hospitals, other medical providers & other insurers

1. I authorize all hospitals, physicians, medical care providers, insurers and other persons, from all countries, to provide to **Claims at** TuGo all information and documentation in their possession that **Claims at** TuGo requires to process my claim, including: records in regard to illnesses, injuries, medical history, consultations, medicines and treatments of the claimant named below (collectively, the "Medical Records") and other applicable insurance policy information.
2. I authorize **Claims at** TuGo to collect, use and disclose the Medical Records, and the information in the Medical Records, to the selling agent, and to any insurers, including government health plans, that may have a responsibility in this claim.
3. I understand that the purpose for the collection, use and disclosure of the Medical Records and other insurance policy information is to enable **Claims a**t TuGo and insurers to assess and determine the eligibility of and other available insurance for any claim I might submit. I acknowledge and agree that it is my responsibility to provide to **Claims at** TuGo such information and other documentation as may reasonably be required to process my claim and that my failure to do so will jeopardize my entitlement to coverage.
4. I understand that if Medical Records are required from the U.S., this purpose constitutes a payment operation under the privacy rules in the U.S. Health Insurance Portability and Accountability Act.
5. This authorization takes effect on the date set out below. I understand that I may revoke this authorization in writing. I acknowledge and agree that if this authorization is revoked before the Medical Records are collected and reviewed my entitlement to insurance coverage will be jeopardized.

A copy of this authorization received from **Claims at** TuGo shall be as effective and valid as the original.

FIRST NAME LAST NAME

Print name (and relationship if not claimant)

X _____ MM | DD | YYYY

Signature (Claimant or authorized representative) **Date**