

To make a claim, complete this form and forward to:

**Johnson Fu Insurance Agency Inc.**  
15 Wertheim Court, Suite 501, Richmond Hill ON, L4B 3H7  
Phone: 905-707-1512, Fax: 905-707-1513, Toll Free: 1-877-832-5541

### JF Canada Visitor Claim Form

Claim No. \_\_\_\_\_

#### A. Personal Information

##### Name of Sick or Injured Person

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth DD/MM/YYYY

Passport No. \_\_\_\_\_ Country of Residence \_\_\_\_\_ Email \_\_\_\_\_

GMS Policy No. \_\_\_\_\_ Arrival Date in Canada DD/MM/YYYY Scheduled Return Date to Country of Residence DD/MM/YYYY

##### Canadian Destination Information

Address \_\_\_\_\_ City \_\_\_\_\_

Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Contact Person in Canada \_\_\_\_\_

#### B. Claim Details

Describe Sickness or Injury \_\_\_\_\_ Date of Incident DD/MM/YYYY

Describe How Incident Occurred \_\_\_\_\_ Auto Accident  Yes  No

Total Amount of Treatment \$ \_\_\_\_\_ Currency \_\_\_\_\_ Amount Already Paid \$ \_\_\_\_\_

Attending Physician Name \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Your Physician In Your Country of Residence \_\_\_\_\_ Address \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Did the patient suffer symptoms, receive medical advice, treatment, investigation and/or was medication prescribed or changed for this medical condition in the 120 days immediately before the effective date of coverage?  Yes  No

If yes, please describe \_\_\_\_\_

#### C. Other Insurance Coverage (If the insured is a child, this section is applicable to the parent or legal guardian)

This insurance pays eligible expenses in excess of those covered by any other insurance. Therefore, if at the time of loss you have similar coverage with another provider (e.g. credit card, travel insurer, employment group health plan, private or provincial auto plan, etc.), we will coordinate benefits in accordance with the Canadian Life and Health Insurance Association guidelines.

Do you and your spouse or child have other travel insurance benefits?  Yes  No \* **Please provide details (attach additional information if necessary)**

Type of Plan \_\_\_\_\_ Policy/ID/Credit Card # \_\_\_\_\_

Name and Address of Bank/Credit Card or Insurance Company \_\_\_\_\_

I hereby warrant that I do not have any other travel or out-of-province medical insurance coverage (check if applicable)

#### D. Assignment of Claim Amount

Do you want your claim refund to be paid and forwarded to someone other than yourself?  Yes  No

If yes, complete the following:

Name of Payee \_\_\_\_\_ Address of Payee \_\_\_\_\_

**X** \_\_\_\_\_

**Signature of Policyholder to authorize payment of claim to a third party**

## E. Certification and Authorization

The insurer, its agents, administrators and/or their designated representatives (collectively "Group Medical Services") are obliged to collect and retain certain personal and/or health information about you in connection with your insurance coverage. They use and disclose that information only for the purposes of administering your policy/policies of insurance, providing customer service and assessing and paying claims.

- I/We authorize any licensed physician, medical practitioner, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, provincial health insurance plan and employer(s) to provide Group Medical Services, and their respective representatives employed to assist in the administration of this claim, any information, including personal information, data, or records that are in their possession/knowledge, regarding my medical history and treatment.
- I/We direct and authorize my government health insurance plan (GHIP) to make payment in respect of my claim for out-of-country health services to Group Medical Services directly and I hereby release GHIP, upon payment to Group Medical Services, from any further claim or cause of action in connection herewith.
- I/We hereby consent and authorize GHIP to directly or indirectly collect information contained in the claim and source documents pursuant to the Freedom of Information and Protection of Privacy Act and the Health Information Protection Act.
- I/We authorize Group Medical Services to coordinate the payment of benefits with any other insurance carriers which may also have a liability for this claim.
- I/We hereby authorize irrevocably Group Medical Services to make any payments, receive payments and settle with any carriers on my behalf.

I hereby consent to the collection, use and disclosure by the insurer, its agents and administrators of the personal and health information about me disclosed herein and in all documents or information provided in connection with my policy/policies of insurance for the purposes cited above.

If the undersigned is signing on behalf of any person(s), the undersigned represents to having the authority to sign on behalf of such person(s) and confirms that each of the above declaration and authorizations are also provided on behalf of such person(s) and confirms that each of the above declaration and authorizations are also provided on behalf of such person(s).

A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from date signed.

**X**

(Print Full Name)

DD / MM / YYYY

**Signature of Claimant**

**Claimant**

**Date**

If claimant is dependant, print full name of parent or guardian, or if claimant is deceased, print full name of executor.