TIC travel insurance

TIC Claims & Travel Assistance
125 –4400 Dominion Street
Burnaby, BC, Canada V5G 4G3

Toll Free: 1-800-882-5246
Tel: 604-639-8849
Fax: 604-639-8859

Schedule A

ASSIGNMENT OF PAYMENT DUE TO INSURED PERSON OR BENEFICIARY UNDER THE MEDICARE PROTECTION ACT OR HOSPITAL INSURANCE ACT

BETWEEN: _____ of the first part,
(claimant's name) _____ hereinafter referred
_____ to as the Assignor

AND: O/A TIC Travel Insurance Coordinators Ltd. of the second part, hereinafter referred to as the Assignee

AND: HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF BRITISH COLUMBIA AS REPRESENTED BY THE MINISTER OF HEALTH hereinafter referred to as the Minister

WHEREAS the Assignor is a person eligible for insured services or benefits or both under the Province of British Columbia's Medicare Protection Act or Hospital Insurance Act or both, and as such may receive payment for the above services from the Minister.

AND WHEREAS the Assignor is under a covenant or obligation under a contract with the Assignee to remit to the Assignee all such payments received for medical services from the Minister.

NOW WITNESS THAT in consideration of the said obligation to the Assignee the Assignor hereby assigns unto the Assignee all sums of money that shall be owing to the Assignor by the Minister for the above noted contract. The Minister is hereby authorized to pay all such sums directly to the Assignee at the aforesaid, or at any address the Assignee may from time to time designate, with payment of any such sum to be sufficient discharge to the Minister of and from any indebtedness in that amount to the Assignor, his heirs, executors, or administrators.

DATED this _____ day of _____ , 20 _____

_____
Signature of Assignor (Insured)
(parent/guardian if minor)

WITNESS:

_____ Signature

_____ Occupation

ASSIGNMENT:

Effective from ___/___/___
DD MM YY

To ___/___/___
DD MM YY

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Schedule B

AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

I, _____ (or I, _____ parent/guardian of _____, a minor) hereby consent to and authorize the Ministry of Health to furnish to any representative of TIC Travel Insurance Coordinators Ltd. any and all records and information in the Ministry of Health's possession regarding claims for Medical Services incurred while I had insurance coverage from _____ (DD / MM / YYYY) to _____ (DD / MM / YYYY) including medical history and physical condition both prior and subsequent to receipt of Medical Services, regardless of lapsed time and bearing in any way on the Services received during the above time period.

DATED this _____ day of _____, 20 _____

_____
Personal Health Number

_____
Signature of Insured
(if minor, parent/guardian)

_____
Address

_____
Telephone

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