Insurance Agency Group Inc.
www.jfiginsgroup.com

JF ROYAL VISITORS TO CANADA
EMERGENCY HOSPITAL & MEDICAL INSURANCE
CLAIM FORM

Ontime Care Worldwide Inc.
15 Wertheim Court, Suite 512
Richmond Hill, Ontario L4B 3H7
Collect worldwide: 905-918-0188
Toll free Canada/US: 1-888-988-3268

INSTRUCTIONS

IMPORTANT

- **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.
- 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.

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:_____

Country of Origin:_____ Date of Arrival in Canada:_____

Name and Address of Family Physician in Country of Origin

Full Name:_____

Street Address:_____

City/Town:_____ Postal Code: _____ Telephone: (_____)_____

Name and Address of Family Physician in Canada

Full Name:_____

Street Address:_____

City/Town:_____ Postal Code: _____ Telephone: (_____)_____

Do you have **other insurance** coverage including Canadian government health insurance? ❑ Yes ❑ No

Do you have insurance coverage through your spouse? ❑ Yes ❑ No If 'Yes', please provide name and address of other insurance company/coverage:

Full Name:_____

Street Address:_____

City/Town:_____ Postal Code: _____ Telephone: (_____)_____

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: _____

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 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 Patient/Insured (please print): _____

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

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

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

Date: (MM/DD/YY): _____