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

INSTRUCTIONS

IMPORTANT

- All claims must be reported to Ontime Care Worldwide Inc. ("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.
- We reserve the right to request submission of the original documentation or additional information if needed.

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 physician, a physician's medical report is required for claim submission.
- If you have paid for services, you must submit all itemized invoices and payment receipts from the medical service on provider or hospital detailing treatment and service dates.

  There are two ways to submit your claim:

  1. Online:
     For claims with total expenses less than $1,000, submit your claim with supporting receipts and reports onlineat eclaim.jfgroup.ca. (For claims over $1,000, please submit by mail)
  2. By Mail:
     Mail your completed claim form, original receipts, medical reports to:
     Ontime Care Worldwide, 15 Wertheim Court, Suite 512, Richmond Hill, ON, L4B 3H7
     Please ensure to keep a copy of your claim for your own records.
- Failure to fill out the claim sections fully or provide supporting documentation will delay processing.
- If you have any questions, please contact us by email: claim@otcww.com or contact us by phone at 905-707-3335

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SECTION A: CLAIMANT

Insured's First Name: _____ Last Name: _____

❑Male ❑Female Date of Birth (MM/DD/YY): _____ Policy #:_____

Address in Canada

Street Address: _____ Suite Number: _____

City/Town: _____ Province: _____ Postal Code: _____

Telephone: _____ Email address:_____

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

Name and Address of Treating Physician in Canada

Full Name: _____ Telephone: _____

Street Address: _____ Suite Number: _____

City/Town: _____Province: _____ Postal Code: _____

Name and Address of Family Physician in Country of Origin

Full Name: _____ Telephone: _____

Street Address: _____ Suite Number: _____

City/Town: _____Province: _____ Postal Code: _____

SECTION B: OTHER INSURANCE COVERAGE

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: _____ Telephone: _____

Street Address: _____ Suite Number: _____

City/Town: _____Province: _____ Postal Code: _____

SECTION C: 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: _____

SECTION D: MEDICAL / DENTAL EXPENSE CLAIMED

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

SECTION E: PAYMENT METHOD

Please specify the desired payment method for this claim: ❑ By Cheque ❑ By Email Transfer (For total claims under CAD$1,000 only)

If by cheque, the cheque is payable to: _____

Mailing address: ❑ Same address in section A; Otherwise: _____

If by email transfer, ❑ Same email in section A; Otherwise: _____

Note: Email transfer option is only available for total claim submission under CAD$1,000. You need to have email transfer set up with your financial institution to select this option.

SECTION F: AUTHORIZATION AND CERTIFICATION

Old Republic Insurance Company of Canada ("Old Republic") and OTC are committed to protecting the privacy, confidentiality and security of the personal information we collect, use, retain and disclose. The information provided by you will only be used for determining your eligibility for coverage under the policy, assessing insurance risks, managing and adjudicating claims and negotiating or settling payments to third parties. This information may be shared with third parties, such as other insurance companies, health organizations, and government health insurance plans to adjudicate and process any claim. In the event that we must share your information with a third party who conducts business outside of Canada, there is a possibility that this information could be obtained by the government of the country in which the third party conducts business. We take great care to keep your personal information accurate, confidential and secure. Our privacy policy sets high standards for collecting, using, disclosing and storing personal information. If you have any questions about the company's privacy policy, please visit www.orican.com/privacy, or contact our Privacy Officer at privacy@orican.com or 1-800-530-5446.

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 Old Republic, OTC, or its representatives, any information that is required to process this claim. I assign to Old Republic 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 Old Republic. 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 Old Republic and OTC. I confirm that I am authorized to act on behalf of my dependents for these purposes.

I certify that the information provided in connection with this claim is complete, true and accurate.

Full Name of Patient/Insured (please print): _____

Signature of Insured (if under 18, signature of parent or legal guardian): _____

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

Date: (MM/DD/YY): _____