

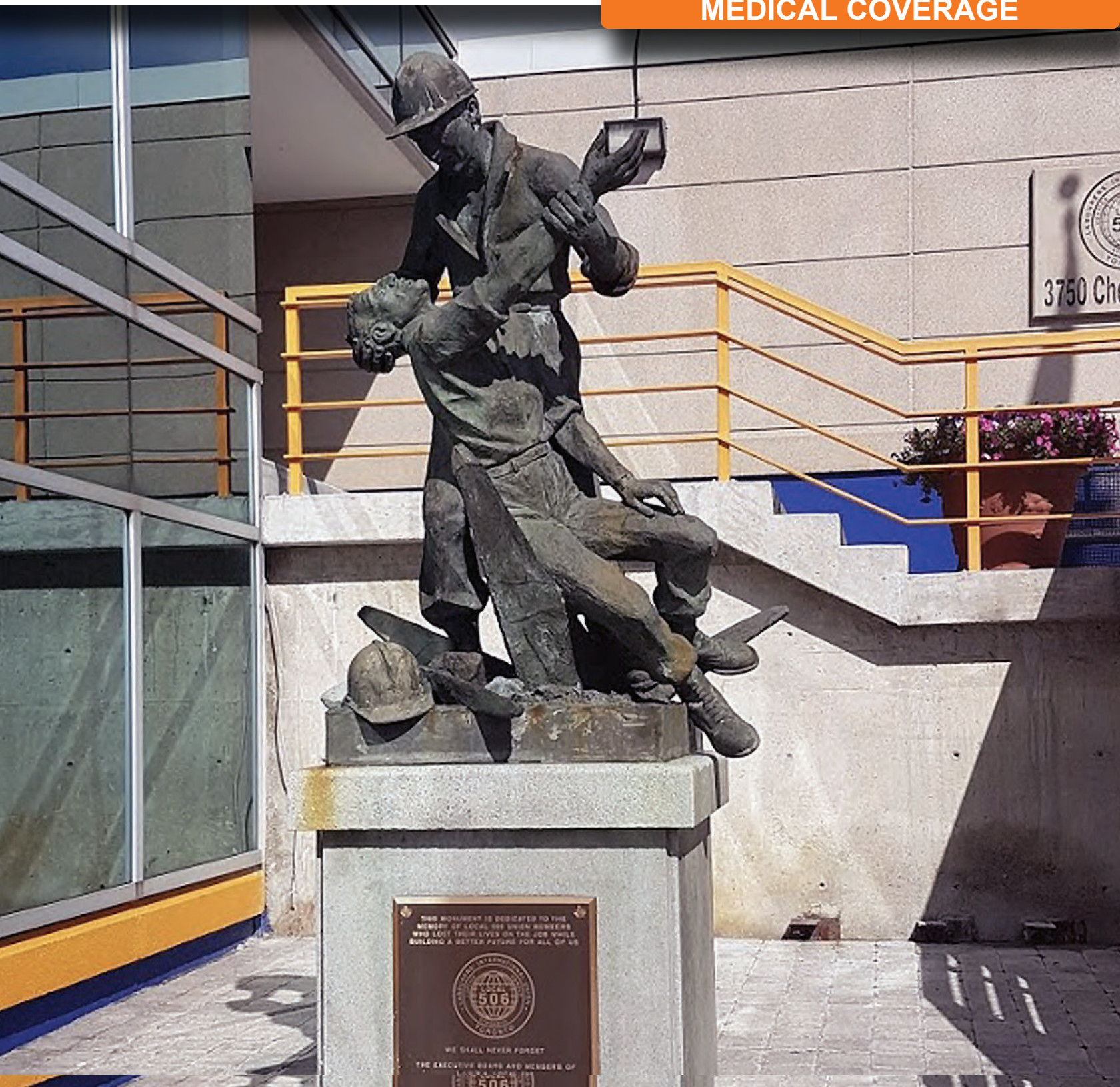
LiUNA!care

LOCAL 506™

BUILDING HEALTHY FUTURES

Labourers' Union Local 506
Members Benefit Trust Fund
RETIRED MEMBERS

**EMERGENCY OUT OF PROVINCE
MEDICAL COVERAGE**



LABOURERS' UNION LOCAL 506 MEMBERS BENEFIT TRUST FUND - RETIRED MEMBERS -

EMERGENCY OUT OF PROVINCE MEDICAL COVERAGE

SUBMISSION INSTRUCTIONS:

- Member to fully complete and sign the Emergency Out of Province Medical Coverage claim form.
- Include all receipts and invoices (originals required). Please keep a copy of completed application package for your records to substantiate your claim.
- Include copies of boarding passes & passport stamps indicating dates of travel.
- Policy No. SRG 9426170.
- Send all original completed applications to:

LiUNAcare Local 506

3750 Chesswood Drive, Suite 1
Toronto, ON M3J 2W6

Tel: 416-506-8841

Fax: 416-506-8833

Email: lifeventclaims@bpagroup.com

Web: www.liunacare506.com

LABOURERS' UNION LOCAL 506 MEMBERS BENEFIT TRUST FUND - RETIREES

Policy Number SRG 9426170

TRAVEL MEDICAL INSURANCE CLAIM FORM



1 LABOURERS' UNION LOCAL 506 POLICY HOLDER INFORMATION

NAME: _____
ADDRESS: _____
CITY: _____ PROV: _____ POSTAL: _____
UNION ID: _____

DATE: _____
HOME PHONE: _____
MOBILE PHONE: _____
EMAIL: _____

2 CLAIM INSTRUCTIONS

1. VERIFY THAT THE ABOVE INFORMATION IS ACCURATE AND MAKE CHANGES WHERE REQUIRED.
2. COMPLETE THIS FORM IN FULL AND ATTACH ALL DOCUMENTS AS REQUESTED.
3. SIGN AND DATE COMPLETED FORM AND RETURN PACKAGE TO:

LiUNAcare Local 506
3750 Chesswood Drive, Suite 1
TORONTO, ON M3J 2W6
P: 416-506-8841
E: info@liunacare506.com

FOR CLAIMS INQUIRIES PLEASE CONTACT: +1 647-258-7274 OR
+1 877-490-7228.

**FAILURE TO COMPLETE THE CLAIM FORM AND ATTACH REQUESTED
DOCUMENTS WILL DELAY THE PROCESSING OF YOUR CLAIM.**

PLEASE ATTACH THE FOLLOWING DOCUMENTS:

- SUBMIT PROOF OF RELATIONSHIP IF NAME DIFFERS FROM YOURS (E.G. MARRIAGE CERTIFICATE/COMMON LAW STATUS/FOR CHILDREN BIRTH CERTIFICATE NAMING PARENTS)
- ALL ORIGINAL MEDICAL BILLS AND PRESCRIPTION RECEIPTS
- DOCUMENTATION CONFIRMING YOUR DEPARTURE AND RETURN DATES (E.G. AIRLINE TICKETS, GAS RECEIPTS, ETC.)
- IN THE EVENT THAT YOU HAVE PAID ANY ELIGIBLE EXPENSES, PLEASE PROVIDE PROOF OF PAYMENT (E.G. CREDIT CARD VOUCHERS, CANCELLED CHEQUES, ETC.)
- A PHOTOCOPY OF THE SICK/INJURED PERSON'S PROVINCIAL HEALTH CARD

PLEASE KEEP A COPY OF ALL THE SUBMITTED CORRESPONDENCE FOR YOUR RECORDS.

WHAT TO EXPECT DURING THE CLAIMS PROCESS

IF YOU HAVE CONTACTED THE EMERGENCY ASSISTANCE CENTRE, WE WILL HAVE ARRANGED TO HAVE ALL BILLS SENT DIRECTLY TO LABOURERS' UNION LOCAL 506 AND ONCE ELIGIBILITY AND PAYABILITY ARE DETERMINED, THE APPROVED PAYMENTS WILL BE SENT DIRECTLY TO THE FACILITIES AND/OR HEALTH PROVIDERS.

IT IS OUR GOAL TO PROCESS ELIGIBLE CLAIMS IN A PROMPT MANNER, HOWEVER PROCESSING MAY BE DELAYED FOR THE FOLLOWING REASONS:

- DELAY IN RECEIPT OF MAIL FROM PROVIDERS
- DELAY IN RECEIPT OF MEDICAL INFORMATION FROM YOUR TREATING OR FAMILY PHYSICIAN
- INCOMPLETE CLAIM FORM AND/OR INSUFFICIENT SUPPORTING DOCUMENTATION

PLEASE NOTE: DUE TO VARIATIONS IN HEALTH BILLING SYSTEMS BETWEEN COUNTRIES, YOU MAY RECEIVE INVOICES OR REMINDER NOTICES DIRECTLY FROM THE HEALTH PROVIDER. SHOULD YOU RECEIVE ANY SUCH CORRESPONDENCE **OR IF YOU HAVE PAID INVOICES DIRECTLY**, PLEASE FORWARD THESE TO THE ADDRESS INDICATED ABOVE.

WE REQUEST THAT YOU SHOULD NOT PAY ANY MEDICAL ACCOUNTS DIRECTLY TO THE PROVIDERS UNLESS YOU HAVE BEEN ADVISED TO DO SO BY WORLD TRAVEL PROTECTION CANADA INC.

SHOULD YOU RECEIVE ANY PHONE CALLS REGARDING YOUR INVOICES. PLEASE DIRECT THE CALLER TO +1 647-258-7274 OR +1 877-490-7228 AND WE WILL PROVIDE THE APPROPRIATE INFORMATION.

**IN ORDER TO EXPEDITE YOUR CLAIM, PLEASE RETURN THE COMPLETED CLAIM FORM AND ALL SUPPORTING DOCUMENTS AS SOON AS POSSIBLE AND
RETAIN A COPY FOR YOUR RECORDS.**

LABOURERS' UNION LOCAL 506 MEMBERS BENEFIT TRUST FUND - RETIREES
Policy Number SRG 9426170
TRAVEL MEDICAL INSURANCE CLAIM FORM



3 INSURED DETAILS

YOUR POLICY NUMBER		
NAME OF ILL OR INJURED PERSON	RELATIONSHIP TO INSURED	DATE OF BIRTH (DD/MM/YYYY)
PROVINCIAL HEALTH PLAN NUMBER OF CLAIMANT	VERSION CODE (IF APPLICABLE, PROVIDE THE LETTERS FOLLOWING THE NUMBER)	
DEPARTURE DATE (DD/MM/YYYY)	RETURN DATE (DD/MM/YYYY)	

4 CLAIM DETAILS

NATURE OF SICKNESS OR INJURY	COUNTRY WHERE INCIDENT OCCURRED	DATE OF INCIDENT (DD/MM/YYYY)
DESCRIBE HOW INCIDENT OCCURRED		
HAVE YOU PAID ANY INVOICES? ☐ YES ☐ NO	IF YES, PROVIDE AMOUNT PAID: \$	CURRENCY
NAME, ADDRESS AND TELEPHONE NUMBER OF ALL PHYSICIANS AND SPECIALISTS THAT THE CLAIMANT HAS SEEN PRIOR TO THE DEPARTURE DATE		
NAME AND SPECIALTY	ADDRESS	TELEPHONE NUMBER
NAME AND SPECIALTY	ADDRESS	TELEPHONE NUMBER

5 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 (I.E. 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. THIS SECTION MUST BE COMPLETED IN FULL. WITHOUT THIS INFORMATION WE WILL BE UNABLE TO PROCEED WITH YOUR CLAIM.

PLEASE PROVIDE DETAILS (ATTACH ADDITIONAL INFORMATION IF NECESSARY)

DO YOU AND/OR YOUR SPOUSE OR CHILD HAVE OTHER TRAVEL INSURANCE BENEFITS? (CHECK ALL THAT APPLY)
☐ EMPLOYER ☐ CREDIT CARD ☐ OTHER TRAVEL INSURANCE ☐ A RETIREE PLAN ☐ HOME, AUTO OR OTHER PLAN ☐ N/A

1. EMPLOYER, RETIREE OR OTHER GROUP PLAN:

NAME (INSURED, SPOUSE, CHILD): _____

INSURANCE COMPANY: _____ POLICY/PLAN #: _____ ID/CERTIFICATE #: _____

EMPLOYER GROUP: _____ EMPLOYER NAME: _____

EMPLOYER PHONE: _____

2. CREDIT/BANK CARD:

ISSUING BANK: _____ CARD NO: _____

3. INDIVIDUAL PLAN:

NAME (INSURED, SPOUSE, CHILD): _____

INSURANCE COMPANY: _____ POLICY/PLAN #: _____ PHONE NUMBER: _____

4. HOME, AUTO, OTHER PLANS:

INSURANCE COMPANY: _____ POLICY/PLAN #: _____ PHONE NUMBER: _____

INSURANCE COMPANY: _____ POLICY/PLAN #: _____ PHONE NUMBER: _____

5. I HEREBY WARRANT THAT I DO NOT HAVE ANY OTHER TRAVEL OR OUT-OF-PROVINCE MEDICAL INSURANCE COVERAGE (CHECK IF APPLICABLE) ☐

LABOURERS' UNION LOCAL 506 MEMBERS BENEFIT TRUST FUND - RETIREES

Policy Number SRG 9426170

TRAVEL MEDICAL INSURANCE CLAIM FORM



6 CERTIFICATION AND AUTHORIZATION

AIG INSURANCE COMPANY OF CANADA, ITS AGENTS AND AUTHORIZED ADMINISTRATORS (HEREINAFTER "THE INSURER", OR "THEY") 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 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 WORLD TRAVEL PROTECTION CANADA INC., AND ITS 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.

SPECIAL GHIP DIRECTION (IF THE CLAIMANT IS A CHILD, THIS SECTION APPLIES TO A PARENT OR LEGAL GUARDIAN)

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 **WORLD TRAVEL PROTECTION CANADA INC. (WTP)** DIRECTLY, AND I RELEASE GHIP, UPON PAYMENT TO WTP, FROM ANY FURTHER CLAIM OR CAUSE OF ACTION IN CONNECTION HERewith.

I CONSENT TO THE DISCLOSURE BY GHIP TO WTP OF SUCH PERSONAL INFORMATION AS MAY BE NECESSARILY REQUIRED FOR PROCESSING OF MY CLAIM, INCLUDING DETAILS OF ANY DUPLICATE PAYMENT PREVIOUSLY MADE DIRECTLY TO ME.

I CONSENT AND AUTHORIZE GHIP TO DIRECTLY OR INDIRECTLY COLLECT INFORMATION CONTAINED IN THE CLAIM AND SOURCE DOCUMENTS PURSUANT TO SECTION 39(1) OF THE FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT, AND TO SECTION 4(2)(F) OF THE HEALTH INSURANCE ACT.

FOR ONTARIO RESIDENTS ONLY: I ACKNOWLEDGE THAT THE INFORMATION COLLECTED AND USED BY OHIP ON THIS FORM AND RELATED TO ANY CLAIMS FOR WHICH I AM ENTITLED TO PAYMENT BY OHIP IS COLLECTED FOR THE PURPOSES OF ASSESSING MY CLAIM, PROCESSING PAYMENT THEREFORE AND ANY RELATED PURPOSES IN ACCORDANCE WITH SECTION 4.1(1) AND 1.1(2) OF THE HEALTH INSURANCE ACT.

I/WE AUTHORIZE WTP, TO COORDINATE THE PAYMENT OF BENEFITS WITH ANY OTHER INSURANCE CARRIERS WHICH MAY ALSO HAVE A LIABILITY FOR THIS CLAIM. I/WE HEREBY IRREVOCABLY DIRECT WTP, TO MAKE ANY PAYMENTS, RECEIVE PAYMENTS AND SETTLE WITH OTHER CARRIERS ON MY BEHALF.

PERSONAL INFORMATION NOTICE

I UNDERSTAND THAT THE INFORMATION PROVIDED BY ME ON THIS CLAIM FORM AND OTHERWISE IN RESPECT OF MY CLAIM, IS REQUIRED BY THE INSURER, ITS REINSURERS TO ASSESS MY ENTITLEMENT TO BENEFITS, INCLUDING BUT NOT LIMITED TO DETERMINING IF COVERAGE IS IN EFFECT, INVESTIGATING THE APPLICABILITY OF EXCLUSIONS. FOR THESE PURPOSES, THE INSURER WILL ALSO CONSULT ITS EXISTING INSURANCE FILES ABOUT ME, COLLECT ADDITIONAL INFORMATION ABOUT AND FROM ME, AND WHERE REQUIRED, COLLECT INFORMATION FROM AND EXCHANGE INFORMATION WITH THIRD PARTIES.

CERTIFICATION

THE STATEMENTS I PROVIDE IN COMPLETING THIS CLAIM FORM AND OTHERWISE IN RESPECT OF MY CLAIMS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. IN THE EVENT OF A FALSE OR MISLEADING STATEMENT IN THE MAKING OF THIS CLAIM, COVERAGE CAN BE CANCELLED, PAYMENT OF BENEFITS DENIED AND PAST CLAIMS PAYMENTS RECOVERED. I AGREE TO REFUND TO THE INSURER, THE AMOUNT OF ANY PAYMENTS MADE IN THE EVENT THAT SUCH AMOUNTS SHOULD NOT HAVE BEEN PAID IN RESPECT OF MY CLAIM. 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.

CLAIMANT (PRINT FULL NAME): _____

IF CLAIMANT IS DEPENDANT PRINT FULL NAME OF PARENT OR GUARDIAN,

OR IF CLAIMANT IS DECEASED PRINT FULL NAME OF EXECUTOR: _____

SIGNATURE: _____ DATE: _____