

Visitors to Canada Claim Form (VCF0703)



PLEASE ENSURE THAT ALL QUESTIONS ARE ANSWERED THOROUGHLY AND DOCUMENTATION REQUESTED (BELOW) IS SUBMITTED WITH THIS CLAIM FORM. FAILURE TO ENCLOSE THIS INFORMATION MAY RESULT IN A DELAY IN PROVIDING A DETERMINATION TOWARDS YOUR CLAIM.

Instructions: In the event of a claim or for claims queries, call North American-wide toll-free at 1 866 228-6386.

You will need to complete this claim form and submit the following documents to:

21st Century Visitor's Claims, c/o Manulife Financial, P.O. Box 4262, Stn A, Toronto ON M5W 5T4

- a) copy of your completed application for insurance or your policy confirmation;
- b) proof of all travel dates of entry into Canada and the USA (airline ticket, passport or visa);
- c) original itemized medical bills, receipts and invoices;
- d) proof of payment;
- e) complete medical and/or hospital records including diagnosis, x-ray, lab or other diagnostic testing results, which confirm that the treatment was medically necessary; and,
- f) copy of police report (in the case of a Motor Vehicle Accident).

Personal Information (to be completed by Insured/Sponsor)			
Male: <input type="checkbox"/>	Female: <input type="checkbox"/>	Date of Birth: _____ <small>M/D/Y</small>	Country of Origin: _____
		Date of Arrival in Canada: _____ <small>M/D/Y</small>	Policy Number: _____
Name of Insured: Last _____ First _____			
Name of Sponsor: Last _____ First _____			
Address in Canada: _____			Telephone Number: _____
Do you have other similar government, private, or group insurance or a credit card providing similar coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, please provide policy details (i.e. policy / card name and policy / certificate number): _____			
Name and address of your physician in your Country of Origin: _____			
Claim Details (to be completed by Insured/Sponsor) NOTE: If there is insufficient space to provide your description below, please attach additional sheets.			
Description of Injury or Sickness which required medical attention, and the cause: _____			
Date symptoms first appeared or date of accident: _____ <small>M/D/Y</small>		Date when medical treatment was first received: _____ <small>M/D/Y</small>	
Have you been diagnosed or showed symptoms of this condition prior to this occurrence? If so, provide date and name of doctor / facility which treated you: _____			
Names, telephone numbers and addresses of all physicians seen for this Injury or Sickness during your trip: _____			
Complete if the treatment was received in the USA	Date of Arrival in the USA: _____ <small>M/D/Y</small>	Planned Date of Return from the USA: _____ <small>M/D/Y</small>	Actual Date of Return from the USA: _____ <small>M/D/Y</small>
Declaration and Consent (to be completed by Insured/Sponsor)			

I declare the answers to each of the above questions on this claim form to be true to the best of my knowledge and belief. Any fraudulent act, misrepresentation or omission committed in the submission of a claim will void the coverage available under this Policy.

In order to facilitate the further administration of the above policy, and particularly the claims process, I authorize The Manufacturers Life Insurance Company (Manulife Financial) and its authorized representatives/agents (including 21st Century Travel Insurance Limited) to collect, use and disclose my personal information as permitted by law and for the purposes necessary to underwrite, investigate, adjudicate and settle claims; detect and prevent fraud; validate information provided; and exchange information with health professionals, assessors, valuers and other insurance related service or information providers, as dictated by prudent insurance industry practices. I understand that Manulife Financial will not collect or disclose medical or financial information without my further express consent, except as provided for herein or in the policy or as otherwise permitted by law. I hereby authorize Manulife Financial and its representatives/ agents to collect and use or disclose my personal information as is necessary to administer the policy, provide services and process claims, which includes the investigation and handling of this matter.

I authorize any hospital, physician or their medical service provider, or any other organization or person that has any records or knowledge of me and my health to release to third party administrators, and Manulife Financial, agents and its reinsurers, any such information for the purpose of this claim.

Check here if you wish to have the proceeds of your claim made payable to your sponsor:

I hereby authorize and direct Manulife Financial to make the proceeds of this claim made payable to my Sponsor, as follows:

Sponsor Name _____ Address _____ Postal Code _____ Telephone _____

Signature of Insured/Patient: _____ Date: _____

If this form was completed by a Sponsor:	
Print Name: _____	Relationship to Insured: _____
Signature: _____	Date: _____

Attending Physician's Statement

To be completed by the Physician – use a separate form for each condition
(Charges for the completion of this form are the patient's responsibility)

NOTE: If there is insufficient space to provide your description below, please attach additional sheets.

Name of Patient: Last First	Date of Birth: M / D / Y
Reason for Visit/Presenting Complaint:	
Diagnosis of Presenting Complaint:	
Reason for Visit: <input type="checkbox"/> Emergency/urgent care (initial visit) <input type="checkbox"/> Emergency/urgent care (follow-up) <input type="checkbox"/> Check-up <input type="checkbox"/> Renewal of medication <input type="checkbox"/> Healthcare assessment for Immigration purposes <input type="checkbox"/> Other, please explain:	
Date of Current Visit:	M / D / Y
When did patient first consult you for this condition?	M / D / Y
Date symptoms first appeared or date of accident:	M / D / Y
If accident, please provide details:	
Will follow-up treatment be required? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide details	
Is patient medically/physically able to return to country of origin after current visit? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, why and when will the patient be fit to travel?	
From patient's case history has he/she ever had the same or similar complaint prior to the first consultation date with you? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please provide details:	
Did another physician treat the patient for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Was patient hospitalized for the current condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide details (i.e. name of hospital and period of hospitalization): Was surgery performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide details:	
Was this condition related to the use of alcohol, misuse of drugs or self-inflicted injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was this condition related to pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Physician Certification:

I certify that the information provided in this section is correct and true to the best of my knowledge and belief:

Signature of Physician

Date

Name of Physician (please print)

Specialty

Physician's Stamp:

Physician's Address

Telephone Number