STATEMENT OF CLAIM
OUT-OF-COUNTRY EXPENSES

Please complete both sides of this form and mail to Canada Life, Attention: Out-of-Country Claims Department PO Box 6000 Winnipeg MB R3C 3A5.

When submitting your claim, be sure to attach the required provincial forms available to you by visiting www.canadalife.com or by calling our Out-of-Country Claims Department at 1.800.957.9777.

Completion of **these** forms will allow us to pay eligible claims and coordinate payment directly with your provincial health plan or with any other insurance carriers.

GENERAL INFORMATION

Name of Employee _____

Complete Mailing Address _____

_____ Phone Number _____

Employer _____ Plan Number _____ I.D. Number _____

I authorize the release of any information or record(s) requested in respect of this claim to Canada Life or its agents and certify that the information given herein is true, correct, and complete to the best of my knowledge.

Employee's Signature _____ Date _____

At Canada Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

I authorize Canada Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Canada Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge. I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

PATIENT INFORMATION

Name of Patient _____ Birthdate _____

Relationship to Employee _____ Purpose for Travelling _____

Date of Departure _____ Scheduled Return Date _____

Actual Return Date _____ Country Visited _____ Currency Used _____

Please provide a brief description of the illness/injury which required treatment outside Canada:

_____

_____

_____

_____

_____

Date of initial onset of symptoms _____ 1st date you received medical attention for these symptoms _____

Prior to leaving Canada, was the patient aware of, or receiving treatment for this condition? ☐ Yes ☐ No

If yes, what was the last treatment date in Canada? _____

I authorize Canada Life to make payment directly to the providers of the service.

Employee's Signature _____

canada life

STATEMENT OF EXPENSES

Total number of invoices/bills included with this claim _____

Please itemize the expenses below. Attach a separate page if additional space is needed.

DATE	PROVIDER	AMOUNT
	TOTAL DOLLAR VALUE OF BILLS SUBMITTED	$ 0.00

STATEMENT OF OTHER INSURANCE

Are you or any other member of your immediate family entitled to travel and/or medical insurance benefits under any other policy, including other group coverage through employment, individual/private travel plans, or credit card plans that will cover a portion of this claim?

☐ **YES** ☐ **NO**

If Yes, please provide the following information:

Type of other Coverage: (group, individual, credit card)		**Name and phone number of Other Carrier:**	
Policy or Plan Number:		**I.D. Number:**	

Have you sent a claim and/or otherwise contacted the other carrier about this claim? ☐ **YES** ☐ **NO**

Please sign the following statement if you have other insurance. This allows us to coordinate the payment of your claim with other insurance carriers. This statement must be signed before any benefits can be paid.

I _____ *hereby authorize Canada Life and it's agents to*
(signature)

coordinate the payment of benefits with any other insurance carriers which may also have a liability for this claim. I hereby irrevocably direct Canada Life to make payments, receive payments, and negotiate settlements with providers and other carriers on the patient's behalf.

I further authorize Canada Life to release and/or receive medical information from providers and other carriers to facilitate the payment and coordination of this claim.

BRITISH COLUMBIA | Health InsuranceBC

SCHEDULE A
ASSIGNMENT OF PAYMENT

Personal Health Number (PHN) of Patient

BETWEEN

Assignor (Adult Patient, or Parent/Guardian of Patient)

AND

Assignee (Insurance Company)	MSP Account Number
	900

AND

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

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

And WHEREAS the Assignor is bound by an obligation under a contract or agreement with the Assignee to remit to the Assignee all payments received for such insured services and/or benefits from the Minister.

THEREFORE, in consideration of the obligation to the Assignee, the Assignor hereby assigns to the Assignee all sums of money that shall be owing to the Assignor by the Minister in relation to the insured services and/or benefits referred to above. The Minister is hereby authorized to pay all such sums directly to the Assignee at the address noted above, or at any address the Assignee may from time to time designate, with payment of any such sum to be a complete discharge of the Minister from any indebtedness in the amount to the Assignor, his heirs, executors, or administrators.

By signing this form, you will be assigning your MSP and hospital insurance benefit to the insurance company (Assignee) named above.

Payment assignment is effective from: _____ to _____
(YYYY / MM / DD) *(YYYY / MM / DD)*

_____ _____
Signature of Assignor (Patient or Parent/Guardian of Patient) *Date Signed (YYYY / MM / DD)*

BRITISH COLUMBIA | Health InsuranceBC

SCHEDULE B
AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

Personal Health Number (PHN) of Patient

Name of Adult Patient, or Parent/Guardian of Patient	Name of Minor-aged Patient (if applicable)
Address	Telephone Number

Insurance Company	
Insurance Coverage	
FROM (YYYY / MM / DD)	TO (YYYY / MM / DD)

I, the above-named adult, hereby consent to and authorize the Ministry of Health ("the Ministry") to provide to an authorized representative of the above-named insurance company("the Insurer"), for the use by the Insurer in assessing entitlement to benefits, any and all records and information in the possession of the Ministry regarding claims for medical or health care services incurred while I had insurance coverage with the Insurer during the period noted above, including records and information relating to medical history and physical condition both prior and subsequent to receipt of the medical or health care services.

_____ *Signature of Adult (Patient or Parent/Guardian of Patient)*

Date Signed (YYYY / MM / DD)

BRITISH COLUMBIA | Health InsuranceBC

OUT-OF-COUNTRY MEDICAL CLAIM

IMPORTANT

- This form must be completed and signed by the patient or their legal guardian
- Please read Section B for claim instructions

SECTION A – PATIENT INFORMATION

PATIENT LAST NAME	PATIENT FIRST NAME(S)	PERSONAL HEALTH NUMBER (PHN)

BIRTHDATE (DD / MM / YYYY)	GENDER	HOME PHONE NUMBER	WORK PHONE NUMBER
	☐ MALE ☐ FEMALE		

MAILING ADDRESS	CITY / TOWN	PROVINCE	POSTAL CODE

RESIDENTIAL ADDRESS (IF DIFFERENT FROM ABOVE)	CITY / TOWN	PROVINCE	POSTAL CODE

HAS PATIENT LIVED AT ABOVE ADDRESS FOR THE 6 MONTHS PRECEDING DEPARTURE FROM BC?

☐ YES ☐ NO IF NO, PROVIDE BELOW THE RESIDENTIAL ADDRESS(ES) WHERE PATIENT WAS LIVING

PREVIOUS RESIDENTIAL ADDRESS 1	CITY / TOWN	PROVINCE	POSTAL CODE	FROM (MM / YYYY)	TO (MM / YYYY)
PREVIOUS RESIDENTIAL ADDRESS 2	CITY / TOWN	PROVINCE	POSTAL CODE	FROM (MM / YYYY)	TO (MM / YYYY)

NAME AND ADDRESS OF PRESENT OR LAST EMPLOYER IN BRITISH COLUMBIA	EMPLOYER OF
	☐ PATIENT ☐ HEAD OF FAMILY

NAME AND ADDRESS OF A PERSON (NOT A RELATIVE) WHO CAN CONFIRM PATIENT'S RESIDENCE IN BRITISH COLUMBIA (INCLUDE POSTAL CODE)

REASON FOR ABSENCE FROM BRITISH COLUMBIA

☐ VACATION ☐ STUDENT
☐ MOVED ☐ BUSINESS TRIP
☐ OBTAIN MEDICAL CARE ☐ OTHER (SPECIFY):

	MONTH	DAY	YEAR
DATE OF DEPARTURE FROM BC			
DATE OF RETURN TO BC			

DO YOU HAVE EXTENDED HEALTH BENEFITS INSURANCE OR TRAVEL INSURANCE?	IF YES, NAME OF COMPANY	POLICY NUMBER
☐ YES ☐ NO		

ARE YOU OR ANY DEPENDENTS COVERED BY HEALTH INSURANCE IN ANOTHER COUNTRY?

☐ YES ☐ NO ***If yes, attach statement of payment of claims***

RELEASE OF INFORMATION

I, the patient named above, hereby authorize Medical Services Plan to obtain information necessary for the processing of my claim from the Hospital and/or Doctor who provided care or in the event of an appeal on this case to provide the appeal board with the appropriate information in order for an informed decision to be made.

I also authorize Medical Services Plan to provide/obtain information to/from the above named travel insurance or extended health benefits company.

In addition, my signature below is my Application for Benefits under the *Hospital Insurance Act* of British Columbia.

I certify that I am the person entitled to receive benefits and that all statements made by me are true and correct.

	If legal guardian, provide name and relationship to patient	
SIGNATURE OF PATIENT / LEGAL GUARDIAN	NAME OF LEGAL GUARDIAN	CONTACT PHONE NUMBER
	RELATIONSHIP TO PATIENT	
DATE SIGNED	RESIDENTIAL ADDRESS	

Personal information is collected under the authority of the *Medicare Protection Act*, the *Hospital Insurance Act* and section 26 (a), (c) and (e) of the *Freedom of Information and Protection of Privacy Act* for the purposes of administering provincial health care benefits. If you have any questions about the collection and use of your personal information, please contact the Health Insurance BC Chief Privacy Office at Health Insurance BC, Chief Privacy Office, PO Box 9035 STN PROV GOVT, Victoria, BC V8W 9E3 or call 604 683-7151 (Vancouver) or 1 800 663-7100 (toll-free).

SECTION B - GENERAL INFORMATION

CLAIM INSTRUCTIONS

- Attach original receipts and billing invoices to your claim.
- Claims for physician services must be received within 90 days
- Claims for hospital services must be received within 6 months, of the date of discharge
- Receipts and billing invoices not in English or French must include a translation.
- Keep copies of your bills and receipts for your records.

IF YOU HAVE PRIVATE TRAVEL INSURANCE OR AN EXTENDED HEALTH CARE PLAN, CONTACT YOUR TRAVEL PLAN BEFORE SENDING YOUR CLAIM TO HEALTH INSURANCE BC (HIBC).

FOR MORE INFORMATION:

Ministry of Health and HIBC Website: https://www.health.gov.bc.ca/exforms/msp/occ.html

Please check your claim form is complete and signed.

If the claim indicates the out-of-country physician or hospital has not been paid, payment will be made directly to the out-of-country physician or hospital.

If the claim is for a small amount or if the out-of-country hospital or physician will not accept payment in Canadian currency, payment will be sent to the beneficiary and the beneficiary will be responsible to pay the account.

Please allow **10-12 weeks** for processing.

SEND YOUR CLAIM TO:

HEALTH INSURANCE BC
PO Box 9480 Stn Prov Govt, Victoria BC V8W 9E7

FOR ASSISTANCE, CONTACT:

HEALTH INSURANCE BC
Phone: 604 683-7151 (Lower Mainland), 1 800 663-7100 (Toll-free BC)

PROVINCIAL COVERAGE INFORMATION

EMERGENCY OUT-OF-COUNTRY MEDICAL TREATMENT

When an eligible B.C. resident is temporarily absent from the province and must use emergency medical services in another country, the provincial coverage is limited.

Provincial coverage for emergency out-of-country:

- physician services is limited to the B.C. physician fee rates
- dental surgery performed in an acute care hospital (patient safety/medical complexity) is limited to the B.C. oral surgery fee rates
- in-patient hospital services is limited to a daily maximum payment of $75.00 CAN

Any difference in fees will be the beneficiary's responsibility.

For more information, visit the Ministry of Health website: www.gov.bc.ca/MSPCoverage-LeavingBC

ELECTIVE OUT-OF-COUNTRY MEDICAL TREATMENT

If a B.C. resident leaves Canada to obtain medical services in another country, provincial coverage for elective out-of-country medical services **must be requested PRIOR** to leaving BC.

Important coverage information and the requirement for medical documentation is available on the Ministry of Health website: http://www.health.gov.bc.ca/msp/infoben/leavingbc.html#outsidecan

PROVINCIAL COVERAGE IS NOT PROVIDED FOR:

- services that are not deemed to be medically required, such as cosmetic surgery
- dental office services
- routine eye examinations for persons 19 to 64 years of age
- eyeglasses, hearing aids, and other equipment or appliances
- annual or routine examinations where there is no medical need
- services of counsellors or psychologists
- certified physician assistant
- registered nurse/nurse practitioner
- prosthesis and appliances
- nurse anaesthetist
- health spas and similar facilities
- transportation and accommodation expenses
- supplies and materials
- use of emergency room, private clinic/surgical facility fees
- medical care at the request of a third party
- medical examinations, certificates or tests required for:
  - driving a motor vehicle
  - immigration purposes
  - employment
  - school or university
  - life insurance
  - recreational/sporting activities

PROVINCIAL COVERAGE IS NOT PROVIDED OUTSIDE B.C. FOR

- ambulance services
- massage therapy
- naturopathy
- podiatry
- optometry
- prescription drugs
- physical therapy
- chiropractic
- acupuncture
- home care services
- midwife services

SECTION C – TO CLAIM FOR DOCTOR'S FEE COMPLETE THIS SECTION

REASON FOR SEEKING MEDICAL ATTENTION (DIAGNOSIS)

TREATMENT / PROCEDURE	DURATION OF ANAESTHESIA _____ HRS _____ MIN OR FROM _____ TO _____
LABORATORY TESTS	AMOUNT PAID (ENCLOSE PROOF OF PAYMENT) $
SPECIFY EACH AREA X-RAYED	AMOUNT PAID (ENCLOSE PROOF OF PAYMENT) $

PHYSICIAN INFORMATION (if more than 7 physicians, attach additional page)

***AMOUNT PAID – ENCLOSE PROOF OF PAYMENT**

1

DOCTOR'S NAME AND SPECIALTY | COUNTRY AND CURRENCY | HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO

WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO

DATE OF VISIT: MONTH | DAY | YEAR | TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL | TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM | AMOUNT PAID** $

2

DOCTOR'S NAME AND SPECIALTY | COUNTRY AND CURRENCY | HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO

WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO

DATE OF VISIT: MONTH | DAY | YEAR | TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL | TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM | AMOUNT PAID** $

3

DOCTOR'S NAME AND SPECIALTY | COUNTRY AND CURRENCY | HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO

WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO

DATE OF VISIT: MONTH | DAY | YEAR | TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL | TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM | AMOUNT PAID** $

4

DOCTOR'S NAME AND SPECIALTY | COUNTRY AND CURRENCY | HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO

WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO

DATE OF VISIT: MONTH | DAY | YEAR | TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL | TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM | AMOUNT PAID** $

5

DOCTOR'S NAME AND SPECIALTY | COUNTRY AND CURRENCY | HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO

WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO

DATE OF VISIT: MONTH | DAY | YEAR | TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL | TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM | AMOUNT PAID** $

6

DOCTOR'S NAME AND SPECIALTY | COUNTRY AND CURRENCY | HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO

WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO

DATE OF VISIT: MONTH | DAY | YEAR | TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL | TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM | AMOUNT PAID** $

7

DOCTOR'S NAME AND SPECIALTY | COUNTRY AND CURRENCY | HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO

WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO

DATE OF VISIT: MONTH | DAY | YEAR | TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL | TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM | AMOUNT PAID** $

SECTION D – TO CLAIM FOR IN-PATIENT HOSPITAL CHARGES COMPLETE THIS SECTION

- In-patient hospital charges include registered bed patient, dialysis, and surgical day care.
- Sections A and C must be completed in the fullest possible detail to confirm residency and entitlement for hospital benefits. See Section D for residency requirements.
- A separate application is required for each admission to hospital.
- If the condition of the person requiring admission to hospital does not permit him/her to apply on his/her own behalf, or if he/she is an underage dependent, this form should be completed by a member of the family or some other person having knowledge of the facts.

NAME OF HOSPITAL									
MAILING ADDRESS OF HOSPITAL, INCLUDING POSTAL CODE									
ADMITTING DIAGNOSIS (NATURE OF ILLNESS) AND TREATMENT PROVIDED DURING HOSPITALIZATION									
DATE OF ADMISSION:	MONTH	DAY	YEAR	DATE OF DISCHARGE:	MONTH	DAY	YEAR	HAVE YOU PAID THE HOSPITAL ACCOUNT? ☐ YES ☐ NO	AMOUNT PAID (ENCLOSE PROOF OF PAYMENT) $

RESIDENCY INFORMATION

A person must be a B.C. resident to qualify for medical coverage under MSP. A resident is a person who meets all of the following conditions:

- must be a citizen of Canada or be lawfully admitted to Canada for permanent residence;
- must make his or her home in B.C.; and
- must be physically present in B.C. at least six months in a calendar year, or a shorter prescribed period.*

  * Eligible B.C. residents (citizens of Canada or persons who are lawfully admitted to Canada for permanent residence) who are outside B.C. for vacation purposes only, are allowed a total absence of up to seven months in a calendar year.

For more information:
https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/msp/bc-residents/eligibility-and-enrolment/are-you-eligible