guard.me® CANADA

EMERGENCY MEDICAL EXPENSE CLAIM FORM

PLEASE PRINT CLEARLY

guard.me Policy Number:
Organization or School Name:
Name of Insured/Patient:
Coverage Start Date:
Coverage End Date:
Date of Birth:

Who do we pay: And How: ○ **Cheque (Make cheque payable to):** ○ **Direct Deposit to Canadian Bank Account (Attach VOID cheque)**

Name _____

Address _____

Tel: _____ **Fax:** _____ **Email:** _____

1. **Do you have any other insurance?** ○ **NO** or ○ **YES** (Include any other medical insurance in Canada.) If YES, provide details:

_____

2. **BC students only: Do you have a study permit?** If yes, please attach copy.

3. **Were you hurt in an accident?** ○ **NO** or ○ **YES** Tell us what happened, when and where the accident occurred, and if a vehicle was involved:

_____

_____

4. **Tell us WHEN and WHY you saw the doctor (below).** Original bills and receipts must be sent with this Claim Form for us to pay you.

Date (d/m/y)	Cost/Currency	Why you needed medical care (Diagnosis)

FOR DIRECT BILLING BY MEDICAL PROVIDERS ONLY

For prompt reimbursement as detailed below, FAX this signed form to guard.me

○ **Rx given** ○ **X-ray Ordered** ○ **Lab work Ordered** ○ **Other/Details**

A) Is this emergency treatment, medically necessary to identify and/or treat an acute, unexpected sickness? ○ **NO** *or* ○ **YES**

OR B) Is this treatment pre-arranged and/or given to maintain the stability of a chronic sickness or condition? ○ **NO** *or* ○ **YES**

AND C) Did the same or similar conditions occur in the 90 days prior to the Coverage Start Date? ○ **NO** *or* ○ **YES**

If YES, provide details and dates: _____

_____

If you answer YES to A) we will reimburse you directly.
If you answer YES to B) or C), have the insured pay for this visit. Questions? Please call the number below.

Medical Provider's Name **PRINT** Date Medical Provider's Signature **(only required for direct payment)**

ATTACH ALL BILLS and MAIL TO:
guard.me **Claims**
3rd Floor, 80 Allstate Parkway
Markham, Ontario L3R 6H3
TEL: 1 888 756 8428 *or* 905-752-6230
www.guard.me
Medical Providers only Fax to:
1 866 329 6948 *or* 905 752 6235

I, the undersigned, declare that all the information I have provided in this Claim Form is true and complete. I acknowledge receipt of ***Travel Healthcare Insurance Solutions Inc. /*** **guard.me**'s privacy statement. I authorize any hospital, physician, other medical provider or insurer to provide by any secure means my medical record to ***Travel Healthcare Insurance Solutions Inc. /*** **guard.me** and its insurers for the purpose of administering claims. All information is to be held in complete confidentiality and is not to be released to any party apart from those listed above. Use of my email address will be restricted to insurance inquiries unless I initiate email contact. A photocopy or facsimile transmission of this Claim Form is as valid as the original. I assign my right to payment to the party indicated above.

_____ _____

Signature (Claimant) Date

Underwritten by: Old Republic Insurance Company of Canada