Your Out-of-Canada Claim

All Out-of-Canada (OOC) & Out-of-Province claims must be submitted directly to your "Travel Assist" OOC service provider, Allianz Global Assistance, using their claim form.

Please follow these steps:

1. Fully complete the attached Allianz Global Assistance Emergency Medical Expense claim, indicating your RWAM group/certificate number on the form.

2. Since your OOC benefit includes a maximum number of days per trip that you are covered for from the day you leave your province of residence, proof of this departure date will be requested by Allianz Global Assistance if your claim exceeds $1000. To expedite any such claim, 'proof of departure' documents should accompany your claim form. Such proof may include:
   - dated airline, train or bus ticket receipts
   - if you travelled via automobile, dated receipts for gas or meals purchased by you
   - any other dated receipts confirming your last date in your Canadian home province prior to your departure

3. As proof of coverage under your provincial health care plan, attach to the claim a photocopy of the *applicable claimant's* Provincial Health Card.

4. It is recommended that you photocopy your completed Allianz Global Assistance claim form and all documents before submitting your claim, and keep the copies for your own records and reference.

5. Attach your original (i.e. not copies) itemized medical bills and prescription receipts to the completed claim form and mail to:

   Allianz Global Assistance
   P.O. Box 277
   Waterloo, ON
   N2J 4A4

Please Note:

OOC claims generally take longer to process than typical processing times you may be accustomed to for other claims such as EHC or Dental. Allianz Global Assistance may require further information from you, or directly from the invoicing treatment provider. Depending upon the provider and/or the country in which treatment took place, it may take a significant period of time for Allianz Global Assistance to obtain the required information. However their procedures include follow-ups every 21 days from the date information was originally requested, until they receive the required documentation. At that point, their claim turnaround time is 10 business days from date of receipt of ***all*** required documentation.

Should you receive any notices, invoices or related correspondence directly from your OOC invoicing treatment provider, please contact RWAM. On your behalf, we will ask Allianz Global Assistance to address the provider's inquiry directly.

Call: RWAM INSURANCE ADMINISTRATORS INC.
Attention: Heather Aguiar @ Ext #221
Local: 519-669-1632 Toll-free: 1-877-888-RWAM (7926)

EMERGENCY MEDICAL EXPENSE CLAIM FORM

Global Assistance Allianz

P.O. Box 277
Waterloo, ON Canada
N2J 4A4

Please complete, sign and return promptly to Allianz Global Assistance at the address above.
Without this information, we are unable to proceed with your claim.

PATIENT INFORMATION

Patient Name:_____ Case No._____

Address:_____ City:_____ Province:_____ Postal Code:_____

Patient's Date of Birth: _____ (MM/DD/YEAR) ☐ Male ☐ Female Patient's Relationship to Policyholder: _____

Patient's Provincial Health Card Number *(including version code for residents of Ontario)*: _____

RWAM Insured Employee & Group Policyholder Information

Employee's Name: _____ Date of Birth: _____ RWAM Cert No.:_____

Group/Employer Name: _____ RWAM Group No.:_____

TRAVEL DETAILS

Was this your 1st trip outside your home province this year? ☐ Yes ☐ No, this was my _____ stay outside my home province this year.

Departure Date: _____ (MM/DD/YEAR) Anticipated/Scheduled Date of Return: _____ (MM/DD/YEAR) Actual Return Date: _____ (MM/DD/YEAR)

Nature of Travel: ☐ Business ☐ Vacation ☐ Study ☐ Medical Care ☐ Other: _____ Destination: _____

Mode of Travel: ☐ Car ☐ Airplane ☐ Other: _____ If applicable, was Extension of Coverage purchased? ☐ No ☐ Yes (specify)

OTHER INSURANCE INFORMATION

Employer Information
If retired, specify name of employer providing benefits:

Employer Name: _____ Retired? ☐

Address: _____

Phone: _____

Spouse's Name:_____
Spouse's Date of Birth: _____ (MM/DD/YEAR)

Spouse's Employer: _____ Retired? ☐

Address: _____

Phone: _____

Please indicate all other insurance coverage you have through any other insurer: (i.e. employee/retiree/spousal group benefits, enhanced credit cards, personal property such as home/auto or any other purchased travel plan). Attach an additional page if required.

1) Name of Insurer: _____ Phone: _____

Address: _____ Lifetime payable limit on policy? ☐ No ☐ Yes (specify) $_____

Policy No: _____ Certificate No: _____ Signature of Policyholder: _____

2) Name of Insurer: _____ Phone: _____

Address: _____ Lifetime payable limit on policy? ☐ No ☐ Yes (specify) $_____

Policy No: _____ Certificate No: _____ Signature of Policyholder: _____

If trip purchased by **Credit Card**, specify card name: _____ Number: _____ Expiry: _____

Have these bills been filed with any other company? ☐ No ☐ Yes If yes, name and contact info: _____

COMPLETE PAGE 2

Additional documentation will be required for this claim – see below:

- o Original itemized medical bills & prescription receipts if received by patient
- o Completed Provincial Health claim forms (only required if you are a resident of British Columbia or Newfoundland)
- o Proof of Departure is required for claims exceeding $1000
- o Photocopy of the patient's Provincial Health Card
- o Accident Report (if applicable)

If you have questions, please call Allianz at 1-800-363-1835. Our Customer Service Team can help.

MEDICAL INFORMATION

Please describe briefly, the situation leading you to seek medical attention, including the diagnosis.

_____

_____

Were medical services required as result of an accident? ☐Yes ☐No If "Yes", please provide details and include an accident report with this form.

_____

_____

Name of Hospital: _____ Date of Occurrence: _____
MM/DD/YEAR

Did you call Allianz Global Assistance within 24 hours? ☐Yes ☐No Do you have any other claims with Allianz Global Assistance? ☐Yes ☐No

Have you had any of these conditions before? ☐Yes ☐No If "Yes", indicate the date you were **last** treated: _____
(including medications) MM/DD/YEAR

Please list all medications in use **before** your departure date:

_____

When were your medications **last** changed **before** your departure (includes type and dosage): _____
MM/DD/YEAR

Name, Address and Phone No. of your Family Physician: _____

Date of your **last** medical visit (in Canada) before your trip? _____ Country where claim occurred: _____
MM/DD/YEAR

Have you paid for treatment? ☐Yes ☐No If "Yes", please specify: ☐Partial or ☐Paid in Full and submit proof of payment

Total amount being claimed: $_____ Currency: _____

AUTHORIZATION

SPECIAL DIRECTION FOR GOVERNMENT HEALTH INSURANCE PLAN AND OTHER INSURANCE COVERAGE

I direct and authorize my provincial government health insurance plan (GHIP), including OHIP, to make a payment in respect of my claim for out-of-country health services to World Access Canada Inc, doing business as Allianz Global Assistance, directly and I hereby release GHIP, upon payment to World Access Canada Inc. from any further claim or cause of action in connection herewith.
I hereby consent and authorize GHIP, including OHIP, to directly or indirectly collect and use personal information including personal health information related to payment of my claim for out-of-country services (pursuant to Section 39 (1) of the Freedom of Information and Privacy Act, and for Ontario residents pursuant to the Health Insurance Act and the Personal Health Information Protection Act).
I consent to the disclosure by GHIP, including OHIP, to World Access Canada Inc. of such personal information including personal health information that is related to the processing and payment of my claim for out-of-country health services, including the details of any duplicate payment previously made directly to me. I understand that I may withhold my consent to the collection, use, disclosure of such information, however, if I do so my claim cannot be processed and paid.
In consideration of payment made on my behalf, I authorize any benefits paid or payable by any other insurance carrier in respect to this claim, to be assigned in whole or in part to World Access Inc. or, if directed by World Access Canada Inc., to the insurance company underwriting the policy for which such payment was made.

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that I have completed this claim form and that the answers given on Page 1 and Page 2 are complete, current and accurate to the best of my knowledge and belief.
I authorize any physician, hospital or other medical provider who has attended or examined me to release to and exchange with Allianz Global Assistance or its representatives any and all information regarding my medical history, symptoms, treatment, examination or diagnoses for the purpose of adjudicating my claim.
I authorize any other insurance carrier to release and exchange with Allianz Global Assistance or its representatives any medical or benefits payment information relating to this claim.
I understand that if I am a dependant under this plan, the policyholder will have access to information about me related to this claim in connection with administration of this plan.
I agree that a photocopy or facsimile of this authorization shall be valid as the original and that this authorization shall be considered valid for the duration of this claim, but not to exceed two years from the date it is signed. I understand information about me may be reviewed in the event that this plan is audited.

Name of Patient (Please print): _____ Date: _____
MM/DD/YEAR

Canadian Address: _____

Signature of Patient / Designated Legal Proxy *: _____ Phone No: _____

* If the patient is a minor, his/her legal guardian must sign on his/her behalf. If a legal representative other than the patient's legal guardian signs this form, (power of attorney, executor/executrix etc.) the provincial health plan requires proof of "Legal Representative" status.

When sending original documents, be sure to keep a copy for your records.