Chambers Plan
Employee Benefits

J G 3 5 - C H

Travel Health Claim

CLAIMS PROCESSED BY DESJARDINS INSURANCE

Please print your Firm & Certificate #

Firm #	Certificate #

Employee's Last Name _____ Employee's Given Name(s) _____

Employee's Full Mailing Address _____ Date of Birth (YYYY/MM/DD) _____

Patient's Name _____ Relationship to Employee _____ Date of Birth (YYYY/MM/DD) _____

If patient is a dependent child, child is: ❑ physically / mentally handicapped

❑ student (school's name and location) _____

_____ Dates of Studies (YYYY/MM/DD) _____

Departed from Home Province (YYYY/MM/DD) _____ **Originally Scheduled Return (YYYY/MM/DD)** _____ **First Treatment (YYYY/MM/DD)** _____

Are you or your dependents eligible for benefits under any other insurance plan? ❑ Yes ❑ No

If "Yes", family member insured _____

Name and address of insuring company _____ Policy No. _____

This claim is the result of ❑ a sudden illness (go to next section) ❑ an accident (complete the rest of this section)

Type of Accident _____

Date of Accident _____

Details of Accident _____

_____

Location of Accident _____

Name and Address of Lawyer Representing You With Respect to the Accident

_____

_____

Why did you need medical attention? What was the nature of the illness or injury? _____

_____

Attending Physician

Name _____

Address _____

_____

Family Physician at Home

Name _____

Address _____

_____

Were you hospitalized? ❑ No ❑ Yes

If "No," who provided treatment?

Name _____

Address _____

If "Yes," where were you hospitalized?

Hospital Name _____

Address _____

_____

STATEMENT OF EXPENSES (ATTACH RECEIPTS)

	Organization Name on Billing	Date of Service	Amount/Currency
Hospital			
Ambulance			
Prescription Drugs			
Other			

TOTAL Please pay: ❑ the provider or ❑ the individual _____

ALL DOCUMENTS MUST BE TRANSLATED TO ENGLISH/FRENCH PRIOR TO SUBMISSION.

All the information I have provided on the form is accurate and complete, to the best of my knowledge, and I certify that the enclosed receipts represent a claim for services rendered to me and/or eligible members of my family. If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them for the purposes of assessing and paying a benefit, if any. I understand that the fees listed in this claim may not be covered or may exceed my group insurance benefits. I understand that I am financially responsible for the entire cost of services received and that this claim is for reimbursement of eligible charges.

I authorize Chambers of Commerce Group Insurance Plan to collect, use, maintain and disclose personal information relevant to this claim for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining Plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan. A photocopy of this authorization is as valid as the original.

Employee's or Legal Representative's Signature _____

Date _____ Phone (_____) _____

THIS PLAN DOES NOT COVER ANY CHARGES FOR THE COMPLETION OF A FORM OR TRANSLATION COSTS.