ONEWORLD ASSIST

This form will be returned if not completed in full

10th Floor, 6081 No. 3 Road • Richmond, BC V6Y 2B2
Telephone: 604 278 4108 • Fax: 604 276 4593
Canada & USA Toll Free: 1 800 663 0399

International Student Medical Claim

Claim No. _____

(Please print clearly)

Name of the Insured claiming FIRST NAME FAMILY NAME ❍ M ❍ F

Address _____

City _____ Prov. _____ Postal code _____

Telephone: Home [ ] _____ Office [ ] _____

Date of birth M | D | Y Country of residence _____

Passport no. and country of issue _____

Arrival date in Canada M | D | Y Planned departure date from Canada M | D | Y

Travel insurance policy no. **TIS** _____ Effective date M | D | Y

Begin with the first medical treatment in Canada (or U.S. and Mexico if applicable) and specify the Sickness(es) or Injury treated/medical diagnosis, date of treatment, physician's name, cost of treatment and drugs prescribed.

Sickness/Injury & Medical Diagnosis	Date of Treatment	Attending Physician's Name	Cost of Treatment	Drugs Prescribed

1. If hospitalized overnight: Name of hospital _____ Province _____
   Date of admission M | D | Y Date of discharge M | D | Y
2. Have you been treated for the listed sickness(es) before? ❍ Yes ❍ No
   If "Yes", please provide the date(s) and place(s) of previous treatment _____
   _____
3. Please provide the name and address of the last physician who treated you in your country of residence _____
   _____
4. Were you taking any prescribed drugs or medications prior to your arrival date in Canada? ❍ Yes ❍ No
   OR, prior to the effective date of your visitor's coverage? ❍ Yes ❍ No
   If "Yes", please list the names of these drugs or medications _____
   _____
5. Are you covered under any other medical insurance plan or contract? ❍ Yes ❍ No
   If "Yes", please provide: Company name _____ Plan or contract no. _____
6. If you prefer that reimbursement be made payable to someone other than yourself, please print their name below, and provide your signature as authorization.
   Name of payee _____ Relationship to Insured _____

Signature of Insured ✍ _____ **Date** M | D | Y

PLEASE COMPLETE AND SIGN REVERSE SIDE

FAILURE TO PROVIDE ALL INFORMATION REQUESTED IN THIS FORM AND SIGNED MEDICAL AUTHORITY MAY CAUSE EXTREME DELAYS IN PROCESSING YOUR CLAIM.

Please ensure that this completed form is returned promptly to OneWorld Assist Inc. with signed medical authority.

MEDICAL AUTHORITY

All hospitals, physicians, medical care providers, insurers and other persons are hereby authorized to provide to OneWorld Assist Inc. ("OWA") all information and documentation (collectively, "medical records") in their possession regarding illnesses, injuries, medical history, consultations, medicines and treatments of the claimant named below. OWA is authorized to collect and use those medical records and to disclose them and information in them to the selling agent, and to insurers, including government health plans, that may be responsible for the claimant's medical expenses. The undersigned consents to the provision to OWA of medical records from all countries, understands that the purpose for the collection, use and disclosure of medical records is to enable OWA and insurers to determine whether and to what extent the claimant's medical expenses are covered by insurance. If medical records are required from the US, the undersigned understands that this purpose constitutes a payment operation under the privacy rules in the U.S. Health Insurance Portability and Accountability Act. The undersigned also understands that if medical records are not provided those expenses will probably not be covered by insurance.

This consent takes effect on the date set out below and may be revoked at any time by the undersigned in writing. If it is revoked before OWA and insurers collect and review the medical records, the claimant's medical expenses will probably not be covered by insurance.

A copy of this consent received from OWA shall be as effective and valid as the original.

✍ _____

Print name **(and relationship if not claimant)**

✍ _____ M | D | Y _____

Signature **(Claimant or authorized representative)** **Date**