



Travel Health Claim
CLAIMS PROCESSED BY DESJARDINS INSURANCE

Please print your Firm & Certificate #

Firm # _____	Certificate # _____
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First Name _____ Last Name _____

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

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

If the patient is a dependent child, the child: has a physical or mental disability
 is a 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 _____	Location of Accident _____
Date of Accident _____	Name and Address of Lawyer Representing You With Respect to the Accident _____
Details of Accident _____	_____
_____	_____

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

Attending Physician
 Name _____
 Address _____

Were you hospitalized? No Yes
 If "No," who provided treatment?
 Name _____
 Address _____

Family Physician at Home
 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 (_____) _____ Email _____

Exclusions and Limitations

Extended Health benefits are not payable under any of the following circumstances:

- experimental services, treatments or supplies, or charges for services which are not medically necessary;
- drugs, injections or products for the treatment of obesity;
- travel vaccines, patent medicines, general health exams and physicians' fees;
- services or treatment provided by anyone related by blood or marriage or living in the insured's residence (this might come up, for example, if an insured lives with a dentist or pharmacist); or services, treatment or supplies provided to the employee by the employer;
- expenses as a result of intentionally self-inflicted injuries, while sane or insane;
- cosmetic treatment expenses, except as a result of an accidental injury;
- treatment for injuries sustained while committing or attempting to commit a criminal offence;
- expenses for which payment is provided under any Workers' Compensation Act or similar legislation, government plan or any other plan;
- injuries caused directly or indirectly by insurrection and war, or participation in a riot or civil disorder;
- personal comfort items and erectile dysfunction drugs/items;
- forgotten or lost medication refills;
- services, treatment or supplies which the individual received without charge, or amounts in excess of reasonable and customary charges for the least expensive treatment that is medically appropriate;
- travel time, broken appointments, transportation costs, telephone or other indirect consultations;
- expenses related to temporomandibular joint dysfunction;
- expenses related to implants;
- elective treatments and services not listed in eligible expenses;
- out of province referrals.

Please refer to your booklet for complete details on exclusions and limitations.

**For immediate assistance in a medical emergency
outside your province of residence, contact *Voyage Assistance*:**

Inside Canada or the US, call 1 800 465.6390 | Outside Canada or the US, call collect 1 514 875.9170

They are open 24 hours a day, seven days a week to assist with your emergency.

Identifying Yourself

Voyage Assistance needs the following information to identify you as a plan participant.

Group: **Chambers of Commerce Group Insurance Plan**

Insured's Name _____

Firm and Certificate # _____

Effective Date of Coverage _____

The above information is found in the *my-benefits* app under *Benefits*. We recommend you carry a printout of the Benefits card with you when you travel.

Please contact our office for inquiries about your coverage.

**Chambers of Commerce Group Insurance Plan®
1051 King Edward Street, Winnipeg, MB R3H 0R4
1 800 665.3365 (In Winnipeg 204.774.6677)
www.chamberplan.ca**

