Inpatriate/Expatriate Medical & Extended Health Claim Form

Please answer all questions fully – it helps us to provide better service.

All questions can be completed in ink (please print), however, the form must be signed and dated by ALL parties.
Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes.

Instructions to Insured:

1. Complete the Insured's Statement Section and the Extended Health Claim Section on Page 2.
2. Have your Physician complete the Attending Physician Statement Section if the claim is over $500.00.
3. Return the ORIGINAL form, completed and signed, directly to AXA Assurances Inc. at any of the following addresses:
   Exchange Tower 130 King Street West 23rd floor, Suite 2350, PO BOX 160, Toronto Ontario, M5X 1C7
   2020 University Street, Suite 700, Montreal, Quebec H3A 2A5
   220 - 12th Avenue S.W., suite 600, Calgary (Alberta) T2R 0E9
4. Please retain copies of receipts for your files, as originals will not be returned.

Insured's Statement Section

(to be completed in full by the Claimant) **Policy Number:** .....

1. Insured's Full Name _____ Date of Birth D M Y .....

2. Dependent's Full Name (if applicable) | Relationship to Insured/Employee | Date of Birth

.....	_____	D M Y .....
.....	_____	D M Y .....

(if space is insufficient, please use a separate sheet of paper)

3. Name and address of post-secondary school he/she is currently attending if dependent child is age 21 or older.

_____

Please include Proof of Registration/Enrollment

4. Complete Address in Canada .....
   Number & Street City Province Postal Code

5. Complete Address outside Canada .....

6. Email Address (if applicable) _____

7. If Expatriate – indicate date of departure from place of posting D M Y .....
   expected date of return to place of posting D M Y .....

8. Are you or your dependents eligible for benefits under a Provincial Health Plan? ☐ Yes ☐ No
   Any other medical plan? ☐ Yes ☐ No If "Yes", please complete the following
   Name of eligible family member? _____ Relationship? .....
   Name of Insurance Company administering the Plan .....
   Policy Number ..... Type of Coverage .....

9. Please provide the following information if you would like your claim payment deposited to a **Canadian** bank account:
   Bank # _____ Transit # ..... Account # ..... Please attach a "Void" cheque

Assignment

(To be completed by the employee if cheque is to be made payable to the Provider). This assignment is limited to physicians and hospitals for payment over $500.00.

I hereby assign to ..... benefits payable to me, but not to exceed the charge for the services described on this claim form. I understand that I am financially responsible for charges not covered by this assignment. I certify to the best of my knowledge that the statements made are true, correct and complete.

..... D M Y ..... ( ) .....
Signature of Insured Employee Date Telephone Number

Please return completed claim form with the "Consent to collect, use and disclose personal information" form.

Extended Health Claim Section

(to be completed by the Claimant) **Policy Number:** _____

Instructions: All claims must be accompanied by the original receipts, itemized statements or invoices; treatment and diagnosis must be included. Photocopies will not be accepted. If space is insufficient, please use a separate sheet of paper.

Important: Please complete the form in full to avoid delay in processing your claim.

First Name of Claimant	Nature of Illness/Injury	Drug name and strength of each prescription (if not for drugs, state the nature of the expense)	Date of Receipt (D-M-Y)	Cost of each item	Country and Currency	**For Office Use Only** Currency Rate	Canadian Funds

Attending Physician's Section

(to be completed by the Attending Physician)

1. Diagnosis (describe complications, if any) and Procedures

   _____

2. When did the patient first consult you for this condition? D M Y

3. To the best of your knowledge, when did the symptoms first appear or accident happen? D M Y

4. Has patient ever had same or similar condition? ☐ Yes ☐ No

   If "Yes", approximate date(s) of treatment for such condition D M Y | D M Y | D M Y

   State particulars of treatment _____

5. Describe any other disease or infirmity affecting the patient's present condition

   _____

6. Is the condition due to pregnancy? ☐ Yes ☐ No

7. If Yes, what was the approximate date of commencement of pregnancy? D M Y

8. Was the patient hospitalized? ☐ Yes ☐ No If Yes, From D M Y To D M Y

9. Name and address of hospital _____

10. If an operation was performed, state the nature of the operation _____

11. Date Performed D M Y 12. By Doctor _____

13. Physician's Name (please print) _____ Physician's Signature _____

    Address _____

    Street City Province Postal Code

    Telephone ( ) _____ Date D M Y

The patient is responsible for securing the Attending Physician's Statement and for any charges made for its completion.