

Instructions**Complete the form**

1. Attach original invoices, payment receipts and any pertinent medical reports to the form. They will not be returned.
2. Attach a void cheque if you would like the benefits to be deposited in a Canadian bank account.

Submit the form

1. By email: travel.claims.sp@beneva.ca
2. By fax: 1 855 690-9895
3. By mail: Specialized Products, 1225 rue Saint-Charles Ouest, bureau 200, Longueuil QC J4K 0B9

Customer service

1. 1 855 395-2520 (voicemail)
2. By email: travel.claims.sp@beneva.ca

1. Plan member's information

Certificate No.	Policy/Group No.	Email									
		<table><tr><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>M</td><td>M</td><td>D</td><td>D</td></tr></table>	Y	Y	Y	Y	M	M	D	D	Sex at birth: <input type="checkbox"/> F <input type="checkbox"/> M
Y	Y	Y	Y	M	M	D	D				
Last name	First name	Date of birth									
Address											
City	Province	Postal code	Telephone								
Employment status: <input type="checkbox"/> Active <input type="checkbox"/> Retired											

**2. Information about the person concerned by the claim, if applicable
(one form per insured)**

Last name	First name	<table><tr><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>M</td><td>M</td><td>D</td><td>D</td></tr></table>	Y	Y	Y	Y	M	M	D	D	Sex at birth: <input type="checkbox"/> F <input type="checkbox"/> M
Y	Y	Y	Y	M	M	D	D				
Relationship to the plan member: <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent child											
Does the person live at the same address as the plan member? <input type="checkbox"/> Yes <input type="checkbox"/> No											
Is the person a full-time university or CEGEP student? <input type="checkbox"/> Yes <input type="checkbox"/> No											

3. Other health insurance coverage

Private plan	Are you or your family members covered under another private health insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
If so → Name of insurer: _____	
Provincial plan	Are you or your family members covered under a provincial health insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
If so → Provincial plan identification number: _____	

4. Information about the claim – Illness

Date the symptoms appeared:	<table><tr><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>M</td><td>M</td><td>D</td><td>D</td></tr></table>	Y	Y	Y	Y	M	M	D	D
Y	Y	Y	Y	M	M	D	D		
Diagnosis: _____									
Briefly and clearly describe the symptoms that necessitated medical care. _____									

Have you ever experienced this illness or similar problems in the past? ☐ Yes ☐ No

If so → Date:

Provide details: _____

Were you hospitalized for this health condition? ☐ Yes ☐ No

If so → Name and address of the hospital: _____

Hospitalization dates: to

5. Information about the claim – Injury following accident

Date of the accident:

Type of accident: ☐ Motor vehicle ☐ Work related injury ☐ Other, specify: _____

Briefly and clearly describe the accident. _____

6. Information about your trip

Departure date from province: Return date:

City and country where medical care was received: _____

Reason for travel: ☐ Vacation ☐ Work ☐ Education ☐ Other, specify: _____

7. Your family physician’s information

Last name _____ First name _____ Telephone _____

Name of medical facility (ex: hospital, clinic, doctor’s office): _____

Address: _____

8. List of expenses claimed

Service date	Patient’s name	Care or services claimed	Service provider’s name	Amount claimed	Country and currency	Amount paid by another plan, if applicable
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9. Protection of personal information

Protecting your personal information is a priority for Beneva. To find out more about our practices, please consult the Privacy statement located at beneva.ca.

10. Declaration

I consent to Beneva Inc. collecting, using and disclosing any personal information that is necessary for managing my claim. This information may be disclosed to any group insurance policyholder, healthcare professional or intervening party in the health field as well as any service provider (travel assistance service, IT services, etc.) I declare that the information provided is true, accurate and complete to the best of my knowledge. I am authorized by my spouse and my dependents impacted by this form to disclose and receive information regarding them.

X

Signature

Y	Y	Y	Y	M	M	D	D
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Date